

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06501	
BIRTH NO. 66 06501		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SHEETS MARGARET E.		2. DATE AND HOUR OF DEATH June 26-1966 11 15 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP OF BALTO		D. STREET ADDRESS (If rural, give location) 5308 James town Ct #29			
5. SEX F	6. RACE W	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH 5-14-24	9. AGE (In years lost birthday) 42	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Phone Co.		10B. KIND OF BUSINESS OR INDUSTRY C & P Telephone		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 3		17. INFORMANT Harry M. WALLEN	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of Colon		CAUSE OF DEATH (A) Adenocarcinoma of Colon DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 9 months			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none					
19A. DATE OF OPERATION SEPT '65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CANCER (ABOVE)		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 5-14-66 to 6-26-66 , that (I) <u>(we)</u> lost saw the deceased alive on 6-26-66 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>(I)</u> <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Harry M. Walen		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-26-66	
23C. PHYSICIAN'S NAME (Type) Harry M. Walen		23D. ADDRESS 5356 Carriage Court BALTO. MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-66		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION BALTO., MD.		24E. CITY, TOWN, or county		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1966		25B. NAME OF REGISTRAR R. C. F. F. F.		25C. FUNERAL DIRECTOR Witzke F.D. - 4101 Edmondson Ave	
ADDRESS					

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BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 06502					CERTIFICATE OF DEATH					Registered No. 66 06502									
M.E. CASE NO.					1. NAME OF DECEASED					2. DATE AND HOUR OF DEATH									
(Type or Print)					SISSON, MARIE K.					6-24-66 1:15A M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION					(If not in hospital or institution, give street address or location)					A. STATE B. COUNTY									
ST. AGNES HOSPITAL										C. CITY OR TOWN (If outside city limits, write RURAL and give township)									
										WASHINGTON, D.C. V-48									
D. STREET ADDRESS (If rural, give location)										5003 FIFTH AVENUE									
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
FEMALE		WHITE		WIDOWED		8-10-91		74		Retired		MARYLAND							
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
GEORGE JOHNSON					ELLA ROGAN										577 07 3622				
17. INFORMANT										ADDRESS									
ST. AGNES RECORDS-CATON & WILKENS AVE																			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)										(A) DUE TO					Aniline Poisoning				
ANTECEDENT CAUSES										(B) DUE TO					Stomach and intestines - Carcinoma of Rectum				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C) DUE TO									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
										20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
										Yes					Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR?					If in Baltimore City, give exact location				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?									
(Month) (Day) (Year) (Hour)					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>														
22. I certify that (1) (this hospital) attended the deceased from JUNE 11 1966 to JUNE 24 1966, that (2) (we) lost saw the deceased alive on JUNE 24 1966 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE										23B. DATE SIGNED									
PHILIP J WHELAN										6/24/66									
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS									
ST AGNES HOSPITAL																			
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE					24C. NAME OF CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
Burial					6-27-66					Rock Creek					Washington, D. C.				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR					ADDRESS				
JUN 28 1966					R. E. Farley, M.D.					Wigley F. A. - 4101					Emmons Rd.				

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06503	
BIRTH NO. 66 06503		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Joseph J. Dales		2. DATE AND HOUR OF DEATH 26 June 66	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Md.	
FULL NAME OF HOSPITAL OR INSTITUTION 417 S. Gilmore St. Baltimore, 23, Md.		B. COUNTY 1903		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 417 S. Gilmore St.		5. SEX Male		6. RACE White	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 11-28-86		9. AGE (In years lost birthday) 79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Plumber		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Late - Joseph		14. MOTHER'S MAIDEN NAME Late - Pauline	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-8690		17. INFORMANT Mrs. Vera Rahn	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease		CAUSE OF DEATH (A) DUE TO Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 1 yr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Fatty liver		(B) DUE TO Arteriosclerosis		years	
(C) DUE TO —					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION 6/14/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/20/63 to 6/14/66 , that (I) (we) lost saw the deceased alive on 6/14/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE George Vasth				23B. DATE SIGNED 6/27/66	
23C. PHYSICIAN'S NAME (Type) GEORGE VASTH				23D. ADDRESS 206 S. Gilmore Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-66		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 28 1966		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR Wigley A.D. - 4101 Edmondson Ave.		25D. ADDRESS		25E. ADDRESS	

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BIRTH NO. 66 06504		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06504	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				BAIER, CHARLES ALEXANDER			
2. DATE AND HOUR OF DEATH				JUNE 26, 1966 9:10A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
ST. AGNES HOSPITAL				A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)				B. COUNTY			
WILKENS & CATON AVENUES				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
BALTIMORE, MARYLAND				ELLICOTT CITY			
21229				D. STREET ADDRESS (If rural, give location)			
40 25 OVERHILL DRIVE							
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH	
MALE		WHITE		WIDOWED, DIVORCED (specify)		5-26-11	
				MARRIED		9. AGE (In years lost birthday)	
						55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
ACCOUNTANT		ACCOUNTING		MARYLAND		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHARLES				ANNA (ROBL)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			
NO				WILKENS & CATON AVES. ST. AGNES HOSPITAL-BALTIMORE, MD. 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from JUNE 3, 19 66 to JUNE 26, 19 66, that (X) (we) last saw the deceased alive on JUNE 26, 19 66 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
EWALDO WEISS, MD				ST. AGNES HOSPITAL-BALTIMORE, MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/30/66		Crestlawn Cemetery		Ellicott City, Md., Howard Co.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
JUN 28 1966		Robert E. Farkley, M.D.		Harry H. Witzke, 321 Columbia Pike, Ellicott City, Md.			

WATER, CHARLES ALBERT

DET. AGNES THEATRE

WILKINS & SONS
CATTONE, ANTHONY

WILKINS & SONS

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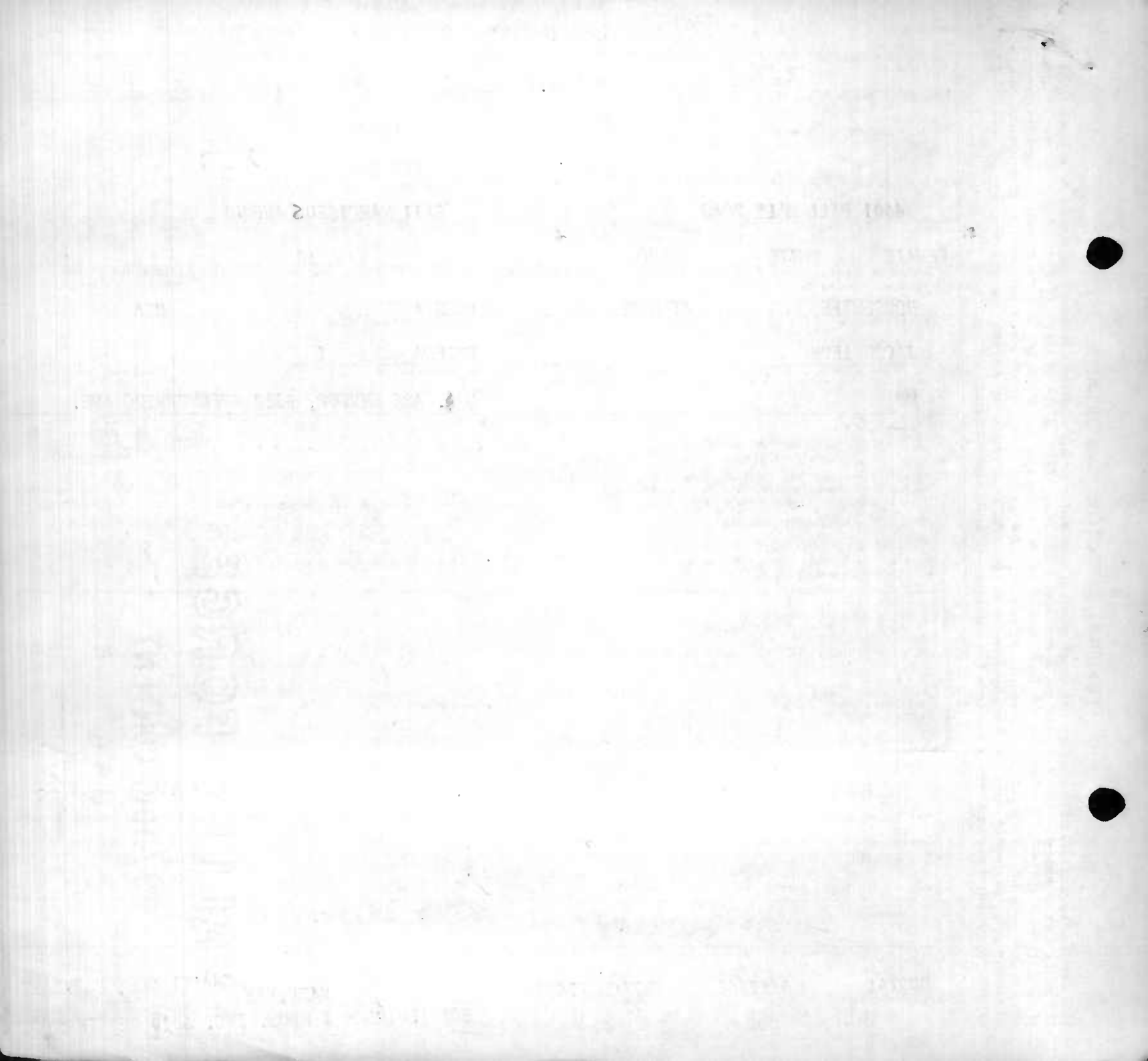
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WILKINS & SONS

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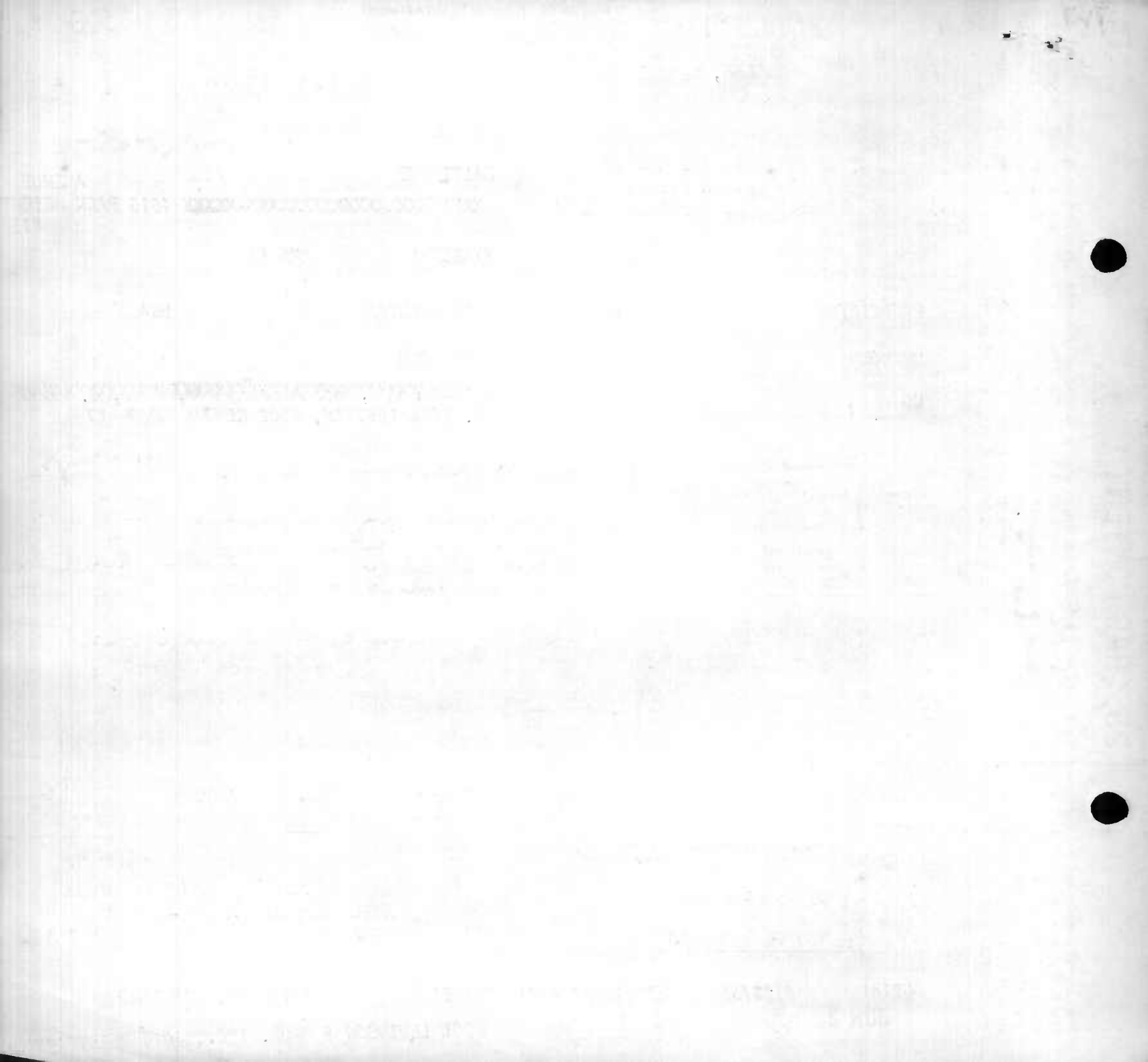
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06505		CERTIFICATE OF DEATH		Registered No. 66 06505	
1. NAME OF DECEASED (Type or Print) Rebecca Snyder				2. DATE AND HOUR OF DEATH 6/25/66 3 P.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jewish Convalescent Home 90 4601 PALL MALL ROAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-19 D. STREET ADDRESS (If rural, give location) 5811 NARCISSUS AVENUE					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH		9. AGE (In years last birthday) 80		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JACOB LEVY			14. MOTHER'S MAIDEN NAME FRIEDA ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS MR. ABE SNYDER, 6320 GREENSPRING AVE.						
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. If means the disease, injury or complication which caused death.) Coronary Thrombosis				(A) DUE TO Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 hour			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO General and cerebral arteriosclerosis		2 days			
(C) arteriosclerosis						8 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 47 19 66 to June 25 19 66 , that (I) (we) last saw the deceased alive on June 25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Louis E. Wice				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/25/66			
23C. PHYSICIAN'S NAME (Type) Louis E. Wice				23D. ADDRESS 920 ST. PAUL ST.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/27/66		24C. NAME of CEMETERY or CREMATORY PETACH TIKVAH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN					



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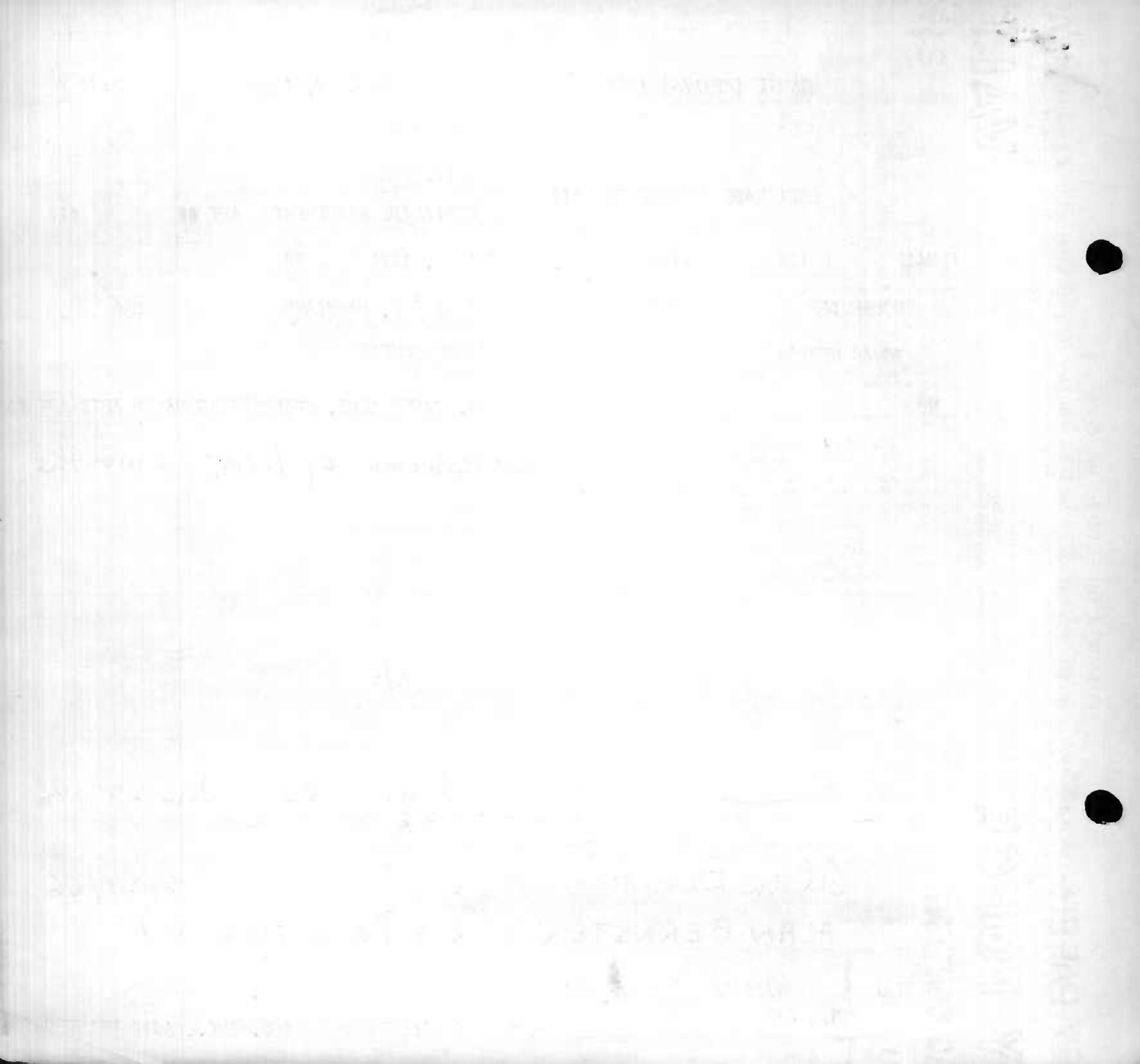
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06506	
BIRTH NO. 66 06506		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MILLER, Samuel		2. DATE AND HOUR OF DEATH 6/26 1966 1 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		BALTIMORE		2746 AVENUE	
31		D. STREET ADDRESS (If rural, give location)		4613 PARK HEIGHT.	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH XXXXXXXX	9. AGE (In years lost birthday) XXX 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. #15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10B. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE PARTS		11. BIRTHPLACE (State or foreign country) LITHUANIA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				MRS. ROSE LEVITAS, 3302 KENJAC ROAD #7	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Uremia		10 days	
ANTECEDENT CAUSES		(B) Chronic pyelonephritis		2	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Status post myocardial infarction, About 1 year			
II		ASVD - chronic brain syndrome			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/6 1966 to 6/26 1966, that (I) (we) last saw the deceased alive on 6/25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Petursson				23B. DATE SIGNED 6/26 '66	
23C. PHYSICIAN'S NAME (Type) M. PETURSSON				23D. ADDRESS 4940 Eastern Avenue - 21224 BALTIMORE CITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/27/66		24C. NAME of CEMETERY or CREMATORY BETH ISAAC ADATH ISRAEL	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. JUN 28 1966		24F. NAME OF REGISTRAR Robert E. Farkner	
24G. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERST.		24H. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

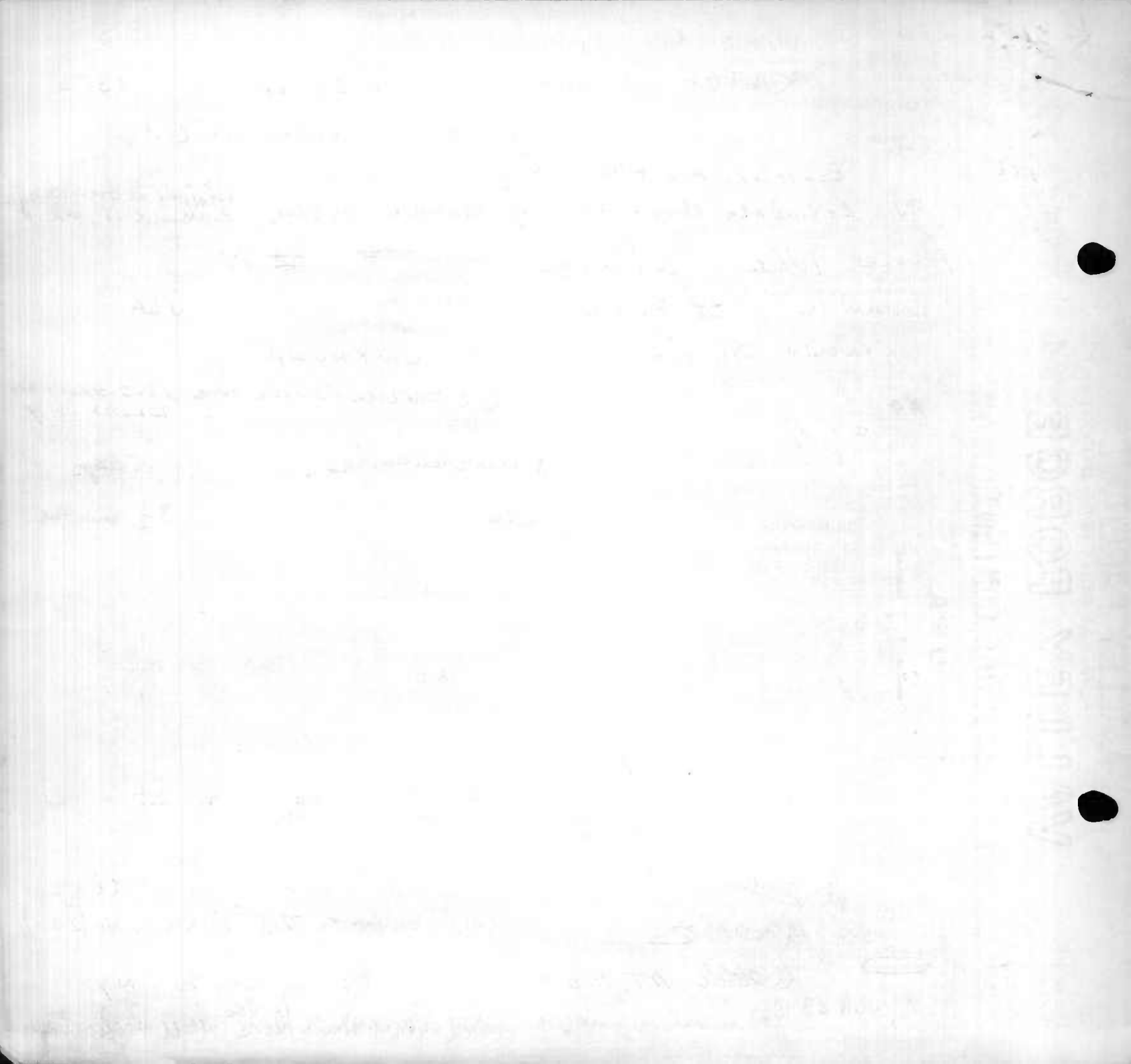
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 06507</u>	
BIRTH NO. <u>66 06507</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MINNIE (HEYMAN) LEVI</u>		2. DATE AND HOUR OF DEATH <u>JUNE 24, 1966</u> <u>9:40 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00 ESPLANADE APARTMENTS #17</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>13-01</u>			
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOW</u>				8. DATE OF BIRTH <u>JULY 2, 1875</u> 9. AGE (in years last birthday) <u>90</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>JONAS HEYMAN</u>			
14. MOTHER'S MAIDEN NAME <u>LAURA SCHWAB</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS <u>MR. JAMES LEVI, GREENSPRING MANOR APTS APT 206</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>1561 I</u> <u>Carcinoma of liver</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 1950</u> to <u>June 24 1966</u> , that (I) (we) last saw the deceased alive on <u>June 24 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <u>Alan Bernstein</u> M.D.				23B. DATE SIGNED <u>6/25/66</u>		23C. PHYSICIAN'S NAME (Type) <u>ALAN BERNSTEIN</u> M.D.	
23D. ADDRESS <u>819 Park Ave (1)</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/26/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>OHED SHALOM</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 66 06508					
BIRTH NO. 66 06508		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) KATOF, Jennie			2. DATE AND HOUR OF DEATH 6-25-66 1:35 a. m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION Belvedere Ave + Greenspring 91 Levindale Home + infirmary					A. STATE Md B. COUNTY Baltimore City					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					D. STREET ADDRESS (If rural, give location) Belvedere at Greenspring Levindale Nursing Home Baltimore 15, Md.					
5. SEX FEMALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED		8. DATE OF BIRTH 1911	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME UNKNOWN SHAPIRO					14. MOTHER'S MAIDEN NAME UNKNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT J.S. GARLICK FUNERAL Home			ADDRESS 1345 Jerome Ave BRONX, N.Y.		
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Bronchopneumonia					INTERVAL BETWEEN ONSET AND DEATH 15 days					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CVA					3 1/2 months					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 3-2-1960 to 6-25-1966 , that (I) (we) last saw the deceased alive on 6-25-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.										
23A. SIGNATURE Joe Ardaiz					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6-25-66		
23C. PHYSICIAN'S NAME (Type) JOSE ARDAIZ					23D. ADDRESS M.D. 5912 Cross Country Blvd., Baltimore, Md (21215)					
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 6-25-66		24C. NAME OF CEMETERY OR CREMATORY MT. HEbron		24D. LOCATION (City, town, or county) (State) FLUSHING LONG IS. N.Y.				
25A. DATE RECEIVED JUN 28 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joe Ardaiz		ADDRESS Inc 6000 Reisterstown Road				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06509	
BIRTH NO. 66 06509		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) REBECCA J. SCHULTZ		2. DATE AND HOUR OF DEATH June 25, 1966 5:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1926 Eastern Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 2-01 D. STREET ADDRESS (If rural, give location) 1926 Eastern Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan. 14, 1894	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME George Collins			14. MOTHER'S MAIDEN NAME Louisa Brandt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS John J. Mueller 1926 Eastern Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X INTERVENTION DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Arteriosclerotic CVD (B) DUE TO Myocardial Infarction (C) DUE TO Coronary Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-26-66 19 to 6-25-66 19 that (I) (we) last saw the deceased alive on 6-18-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theodore T. Hynick M.D.				23B. DATE SIGNED 7-28-66	
23C. PHYSICIAN'S NAME (Type) T. T. HYNICK		23D. ADDRESS M.D. 429 S. Chester ST 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-1966		24C. NAME OF CEMETERY or CREMATORY Baltimore	
24D. LOCATION Baltimore, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. JUN 28 1966			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			

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W-435

66 06510

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 06510

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RUFUS

WALTON

2. DATE AND HOUR PRONOUNCED DEAD

June 26, 1966

11:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

302 N. Fremont Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

302 N. Fremont Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married (Sep)

8. DATE OF BIRTH

May 19, 1920

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Shelton S.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Rufus Walton

14. MOTHER'S MAIDEN NAME

Core Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Sibbie Moore

ADDRESS

Wilmington S.C.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
6/27/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/29/1966

23C. NAME of CEMETERY or CREMATORY

W. Auburn Cem.

23D. LOCATION,

(City, town, or county)

Balto Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 28 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Schroeder St.

ADDRESS

VALLEY IN CHARGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06511				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06511	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WHITE, CAMILLE T.</u>				2. DATE AND HOUR OF DEATH <u>June 26, 1966 12:05 A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 15-02</u>			
				D. STREET ADDRESS (If rural, give location) <u>320 N. Schroeder St.</u>			
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>6/19/1904</u>		9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Alberta Rose</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>Medical Records</u>	
18. <u>332X-260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Basilar artery thrombosis 7 days</u> DUE TO (B) <u>—</u> DUE TO (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes mellitus</u>							
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 24, 1966</u> to <u>June 26, 1966</u> , that (I) <u>we</u> last saw the deceased alive on <u>June 25, 1966</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>Garry N. Rosenbaum</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/26/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>GARRY N. ROSENBAUM</u>				23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/30/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balls Blanton Cem. Balto Md.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		ADDRESS <u>319 N. Schroeder St.</u>	

1911

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66 06512

BALTIMORE CITY HEALTH DEPARTMENT

66 06512

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James T. Smith

2. DATE AND HOUR PRONOUNCED DEAD

6/22/66

11:08 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43

South Baltimore General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

21-02

D. STREET ADDRESS (If rural, give location)

824 W. Ostend St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Nov 21 - 1918

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Annie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Ada Jordon German born Pa.

18.

331X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) ~~DEPTO~~Massive spontaneous intra-cerebral
hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) ~~DUE TO~~

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT ☐
WORKNOT WHILE ☐
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/22/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-27-66

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat Cat

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

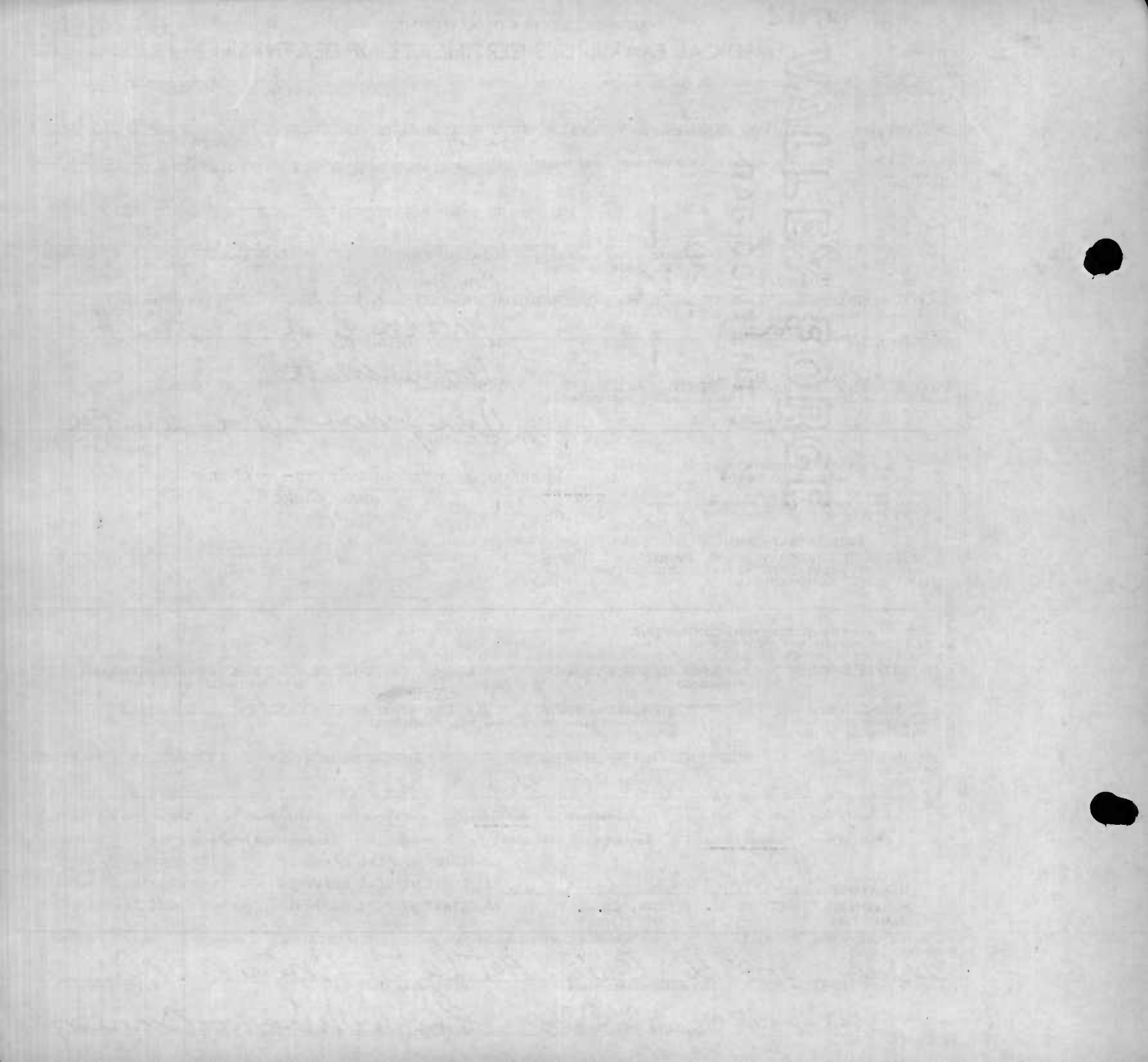
24C. FUNERAL DIRECTOR

ADDRESS

JUN 28 1966

Robert E. Farkner

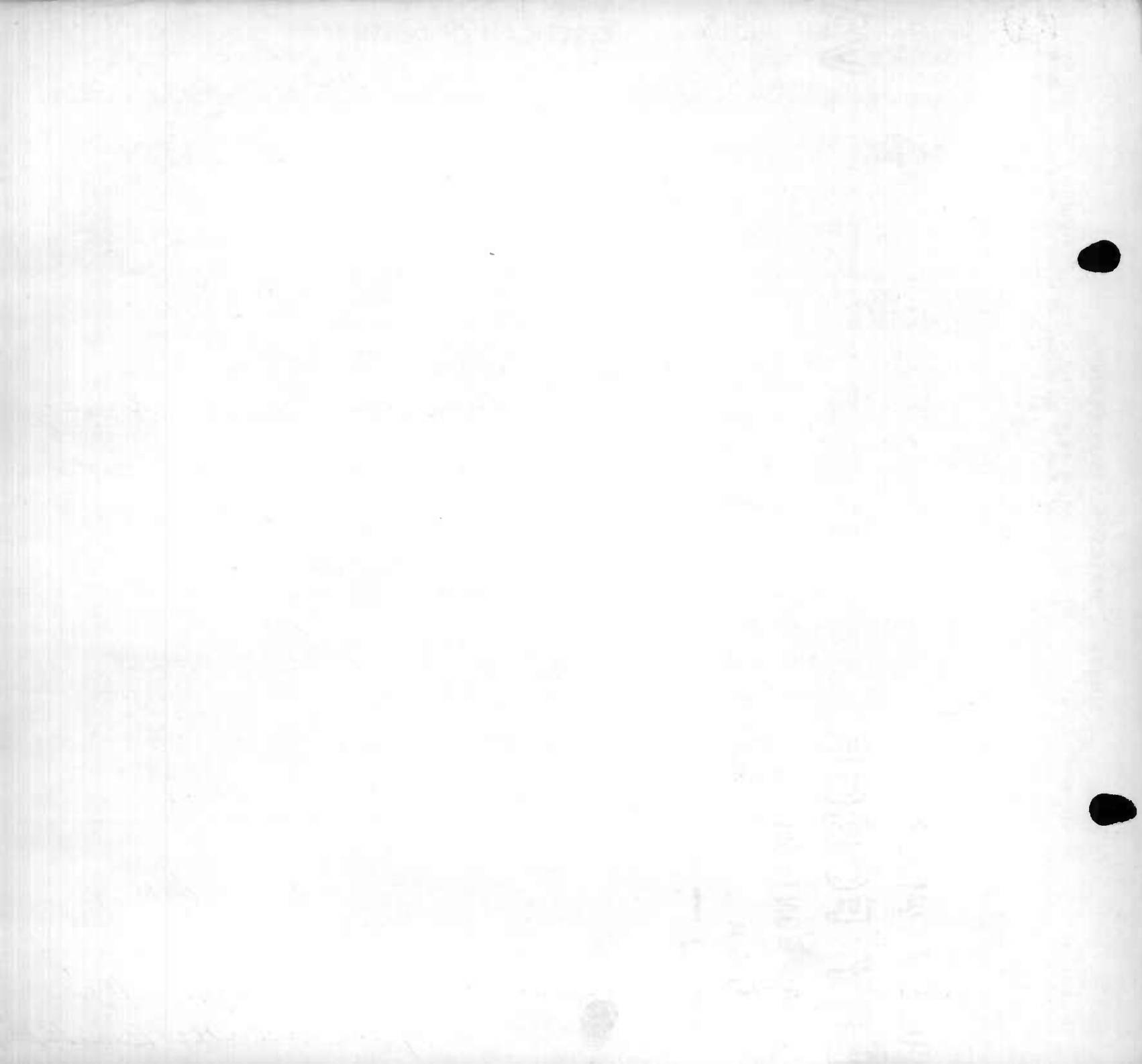
Shoy Wilson 1000 Beantley Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

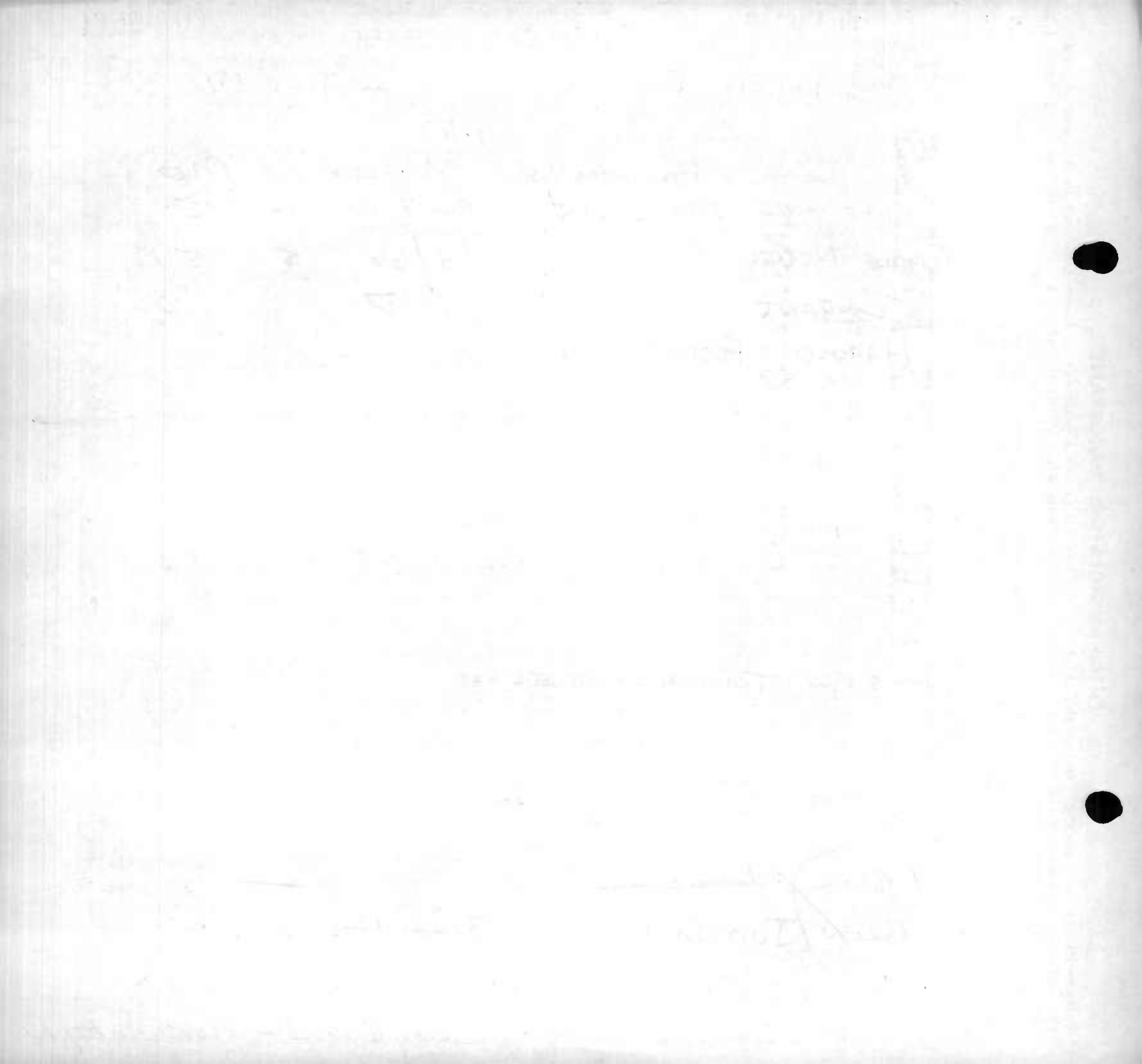
BIRTH NO. 66 06513		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06513	
1. NAME OF DECEASED (Type or Print) William Barnes			2. DATE AND HOUR OF DEATH 6-21-66 1 15 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 3-02 D. STREET ADDRESS (If rural, give location) 1126 E Pratt St Balto 2		
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/31/12	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Cutter		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Will Barnes			14. MOTHER'S MAIDEN NAME Charlotte Savartton		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO.	17. INFORMANT Carmen Barnes		ADDRESS Same
18. 150X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Pulmonary Abscess DUE TO (B) Bronchopneumonia DUE TO (C) Angiomatic Squamous Cell Ca Esophagus		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mos 2 1/2 m 11 m
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 4/21/66 5/21/66 5/23/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED A, C		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/21/66 19 to 6/21/66 19 that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 6/21/66 19 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chester C Collins M.D.				23B. DATE SIGNED 6/21/66	
23C. PHYSICIAN'S NAME (Type) Chester C. Collins				23D. ADDRESS Mercy Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-25-66	24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cent		24D. LOCATION (City, town, or county) (State) Brooklyn Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farkley		25C. FUNERAL DIRECTOR Choy C. Wilson	
				ADDRESS 1000 Beantlife	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

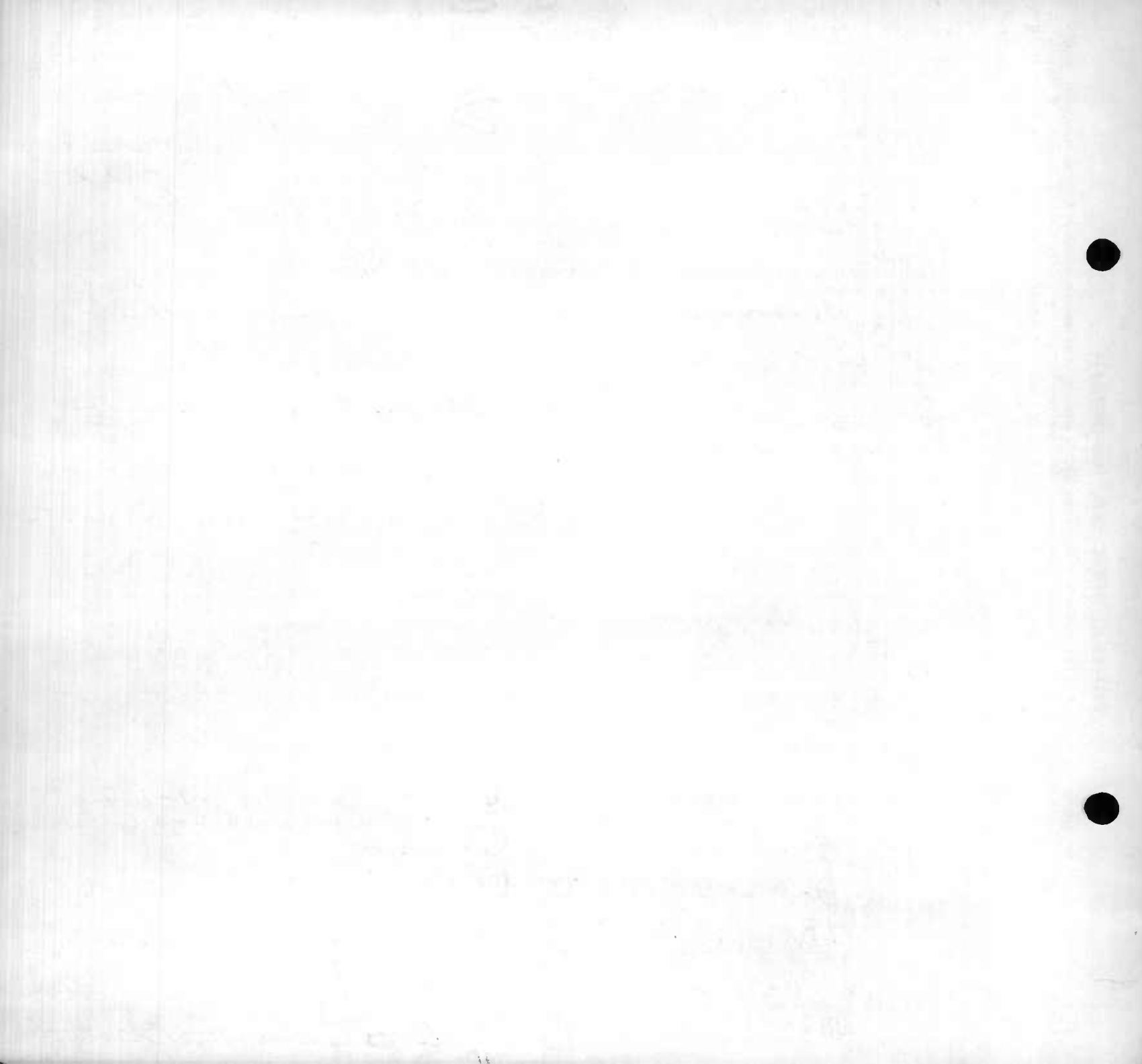
BIRTH NO. <u>66-06514</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 06514</u>	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>KAREN FOSTER</u>			2. DATE AND HOUR OF DEATH <u>23 JUNE 1966 550 P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE INC.</u> <u>421 BALTIMORE MD 21215</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE MD. 27-1F</u>		
D. STREET ADDRESS (If rural, give location) <u>3218 WOODLAND AVE.</u>					
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>1/4/66</u>	9. AGE (In years lost birthday) <u>5</u>	If Under 1 Yr. Months Days <u>5 19</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>HAROLD FOSTER</u>			14. MOTHER'S MAIDEN NAME <u>Ledee Bannan</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ledee Bannan</u>
18. <u>756.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Pneumonia</u> DUE TO (B) <u>Aspiration</u> DUE TO (C) <u>Repaired T-E fistula</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>?</u> <u>birth</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>JAN 5, 1966</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>TRACHEAL ESOPHAGEAL FST.</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>JUNE 22</u> 19 <u>66</u> to <u>JUNE 23</u> 19 <u>66</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>JUNE 23</u> 19 <u>66</u> and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(H)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Allen Judman</u> M.D.				23B. DATE SIGNED <u>23 June 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALLEN JUDMAN</u>				23D. ADDRESS M.D. <u>SINAI HOSP OF BALTO.</u>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <u>6-25-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>not Antenn Cent</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Finkema</u>		25C. FUNERAL DIRECTOR <u>Clay O Wilson 1000 Brantley Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

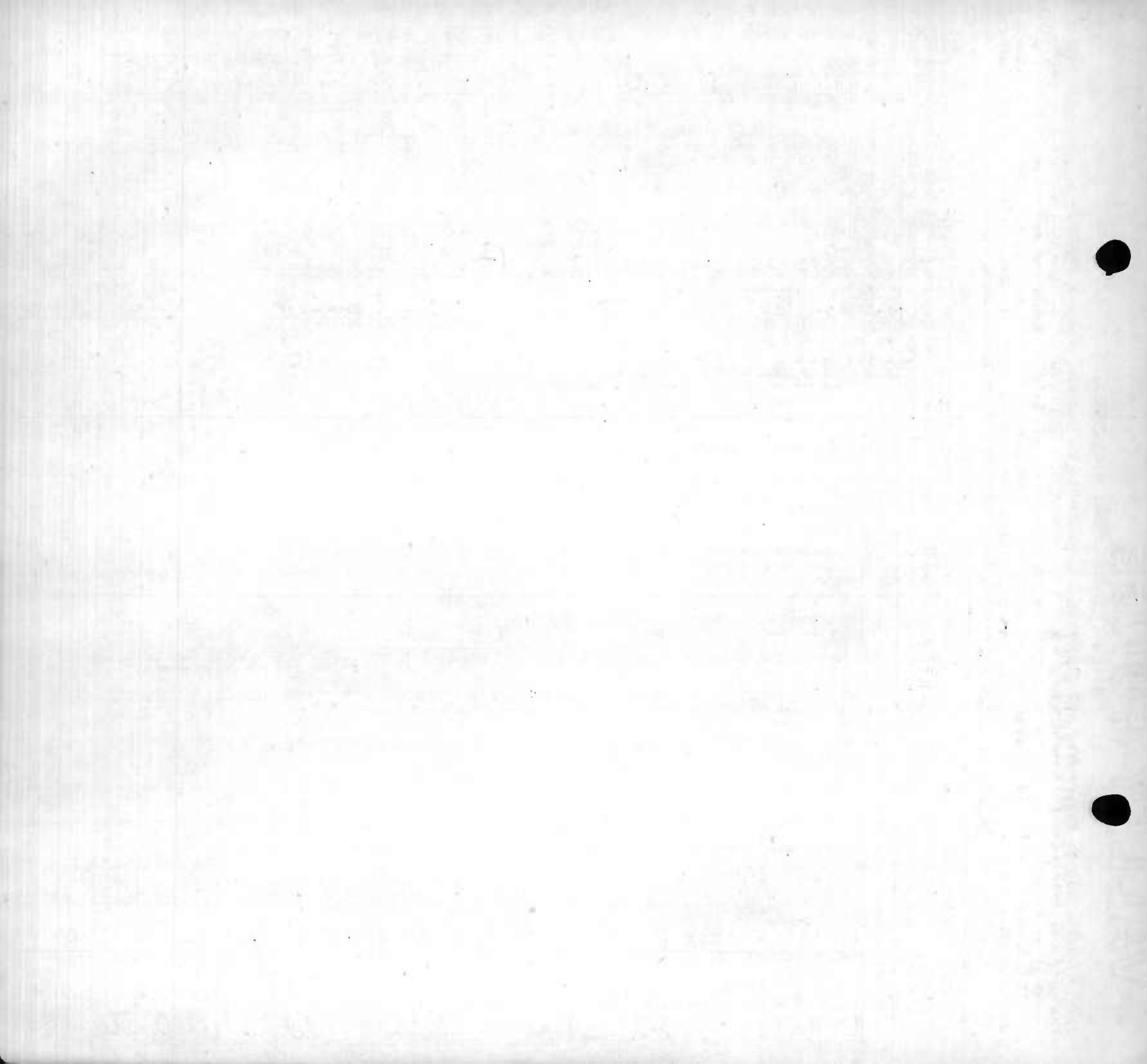
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06515	
BIRTH NO. 66 06515		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) George Merritt		2. DATE AND HOUR OF DEATH June 21 1966 6:00p	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hosp.		A. STATE Maryland		B. COUNTY Baltimore	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 2229 Madison Ave	
6. SEX Female	7. RACE Col.	8. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	9. DATE OF BIRTH Oct 16 - 1895	10. AGE (In years last birthday) 70	11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Mauphin		14. MOTHER'S MAIDEN NAME Hannah Bolton	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Catharine Lawrence Lane	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinoma of Colon		19. CAUSE OF DEATH (A) DUE TO Carcinoma of Colon (B) DUE TO Carcinoma of Colon (C) DUE TO		20. INTERVAL BETWEEN ONSET AND DEATH 3 months 6 months	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
23. MEDICAL CERTIFICATION		24. MEDICAL CERTIFICATION			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-9-66 19 to 6-21-66 19 that (I) (we) lost saw the deceased alive on 6-21-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I Bradshaw Higgins		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-23-66	
23C. PHYSICIAN'S NAME (Type) I Bradshaw Higgins		23D. ADDRESS 2229 Madison Ave, Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-25-66		24C. NAME OF CEMETERY OR CREMATORY Int Arden Cent	
24D. LOCATION Balto		24E. ADDRESS Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1966		25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR Choy O. Wilson	
25D. ADDRESS 1000 Burnside Ave					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

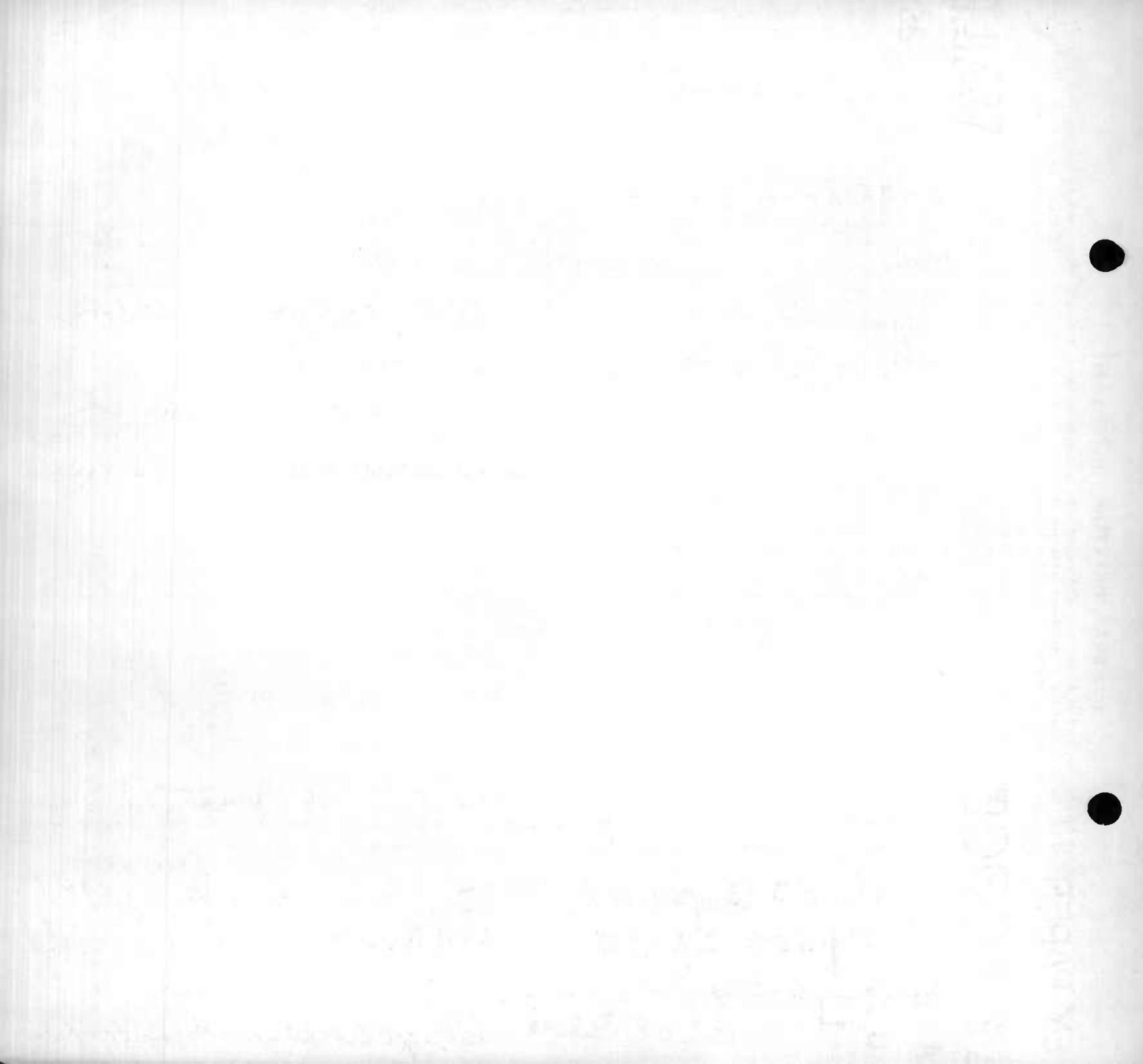
Baltimore City Health Department				Registered No. 66 06516	
BIRTH NO. 66 06516		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DOROTHY BROWN		2. DATE AND HOUR OF DEATH June 24, 1966 10:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital 36		A. STATE Maryland		B. COUNTY Baltimore 19-02	
6. RACE Female Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (specify) Separated		8. DATE OF BIRTH 12/17/15	
9. SEX Female		10. AGE (In years last birthday) 51		11. BIRTHPLACE (State or foreign country) S. Carolina	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Hall		14. MOTHER'S MAIDEN NAME Ella Mae		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT RUTH DAVIS		ADDRESS 206 N. Gilman	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO CVA		INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO Essential Hypertension			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-21-1966 to 6-24-1966, that (I) (we) last saw the deceased alive on 6-24-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ramon U. Suarez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-24-66	
23C. PHYSICIAN'S NAME (Type) RAMON U. SUAREZ		23D. ADDRESS Franklin Sq. Hosp. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-66		24C. NAME OF CEMETERY or CREMATORY Great Falls Cem.	
24D. LOCATION (City, town, or county) (State) Great Falls S. Carolina		25A. DATE REC'D BY HEALTH DEPT. JUN 28 1966		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR		25D. ADDRESS Ethroy O. Walcott 1000 Brantly Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06517</u>	
BIRTH NO. <u>66 06517</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Dennie Overton</u>		2. DATE AND HOUR OF DEATH <u>June 25-1966 10:30 P. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>2435 Lauretta Ave.</u>		A. STATE <u>Maryland</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 20-02</u>			
		D. STREET ADDRESS (If rural, give location) <u>2435 Lauretta Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Col.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 30-1902</u>	9. AGE (In years lost birthday) <u>63</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Samuel Overton</u>		14. MOTHER'S MAIDEN NAME <u>Lorene ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Grace Overton</u>	
				ADDRESS <u>Same</u>	
18. <u>14221 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cardio vascular disease</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>16 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1966</u> to <u>June 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 24, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John E. J. Camper, M.D.</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>June 27, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN E. J. CAMPER</u> M.D.		23D. ADDRESS <u>6391 Carey Street Baltimore Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-29-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cmt</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Clay Wilson 1000 Brantley Rd</u>	



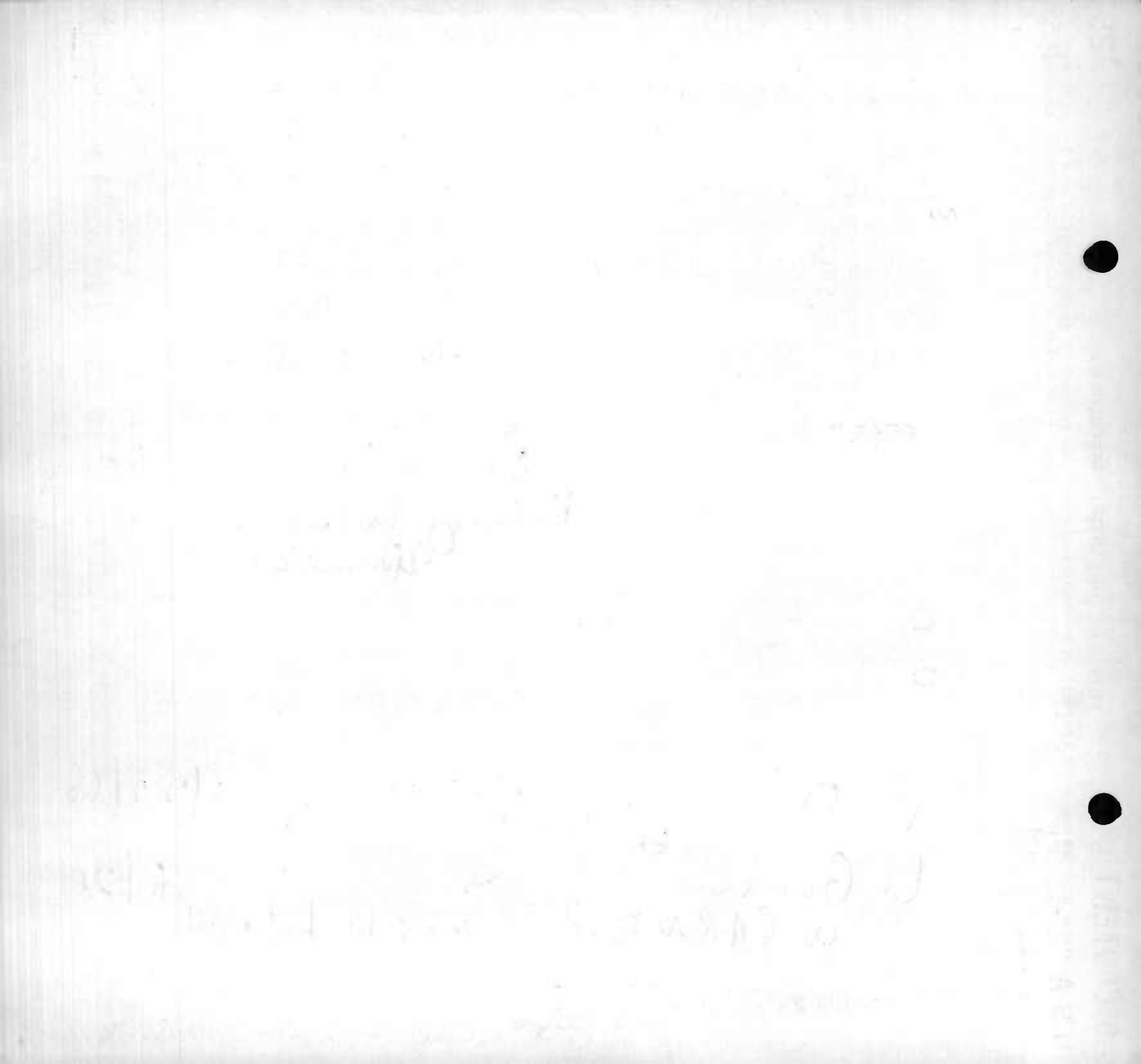
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06518		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06518	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <u>Henretta Walker</u>		
2. DATE AND HOUR OF DEATH <u>June 21, 1966</u> <u>2 45</u> P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>27 S. Caroline St.</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Md. 3-01</u>		
			D. STREET ADDRESS (If rural, give location) <u>27 S. Caroline St.</u>		
5. SEX <u>Female</u>	6. RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>June 1, 1874</u>	9. AGE (In years last birthday) <u>92</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Eastern Shore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Elder Riley Davis</u>		ADDRESS <u>Same</u>
18. <u>332X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>—</u>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>?</u>
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 1965</u> to <u>6-21-1966</u> , that (I) (we) last saw the deceased alive on <u>May 16 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Eugene H. Owens MD.</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Eugene H. Owens MD.</u>				23D. ADDRESS <u>1735 E. Federal St</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-24-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. Calvary Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Brooklyn Md.</u>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <u>Robert E. Farley, MA</u>		25C. FUNERAL DIRECTOR <u>Elmer O. Wilson</u>			
25D. ADDRESS <u>1000 Brantley Ave.</u>					

JUN 28 1966

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06519		CERTIFICATE OF DEATH		Registered No. 66 06519	
1. NAME OF DECEASED (Type or Print) Marie Briscoe				2. DATE AND HOUR OF DEATH June 28, 1966 14 30 A. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 601 W. Lafayette Ave				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 601 W. Lafayette Ave					
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH July 31, 1902	9. AGE (In years lost birthday) 63	11. Under 1 Yr. Months Days If Under 24 Hrs. Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Major Gray				14. MOTHER'S MAIDEN NAME Harriett Rich					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. ALTON Briscoe		ADDRESS SAME	
18. 593X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Pneumonia (B) DUE TO Kidney failure & Anemia (C) _____				INTERVAL BETWEEN ONSET AND DEATH 6 days	
19A. DATE OF OPERATION 6/27/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/27/66 19 to 6/27/66 19 and that (I) (we) last saw the deceased alive on 6/27/66 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE W. Garner				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/28/66			
23C. PHYSICIAN'S NAME (Type) W. GARNER				23D. ADDRESS 1005 W. Lafayette Ave					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE JUN 28 1966		24C. NAME of CEMETERY or CREMATORY MT. Auburn Cem.		24D. LOCATION Baltimore, Md.			
25A. DATE REC'D JUN 28 1966				25B. NAME OF REGISTRAR Robert E. Parker		25C. FUNERAL DIRECTOR Chas. O. Wilson		ADDRESS 1000 BranThy Ave.	



FUNERAL DIRECTOR: IMPORTANT

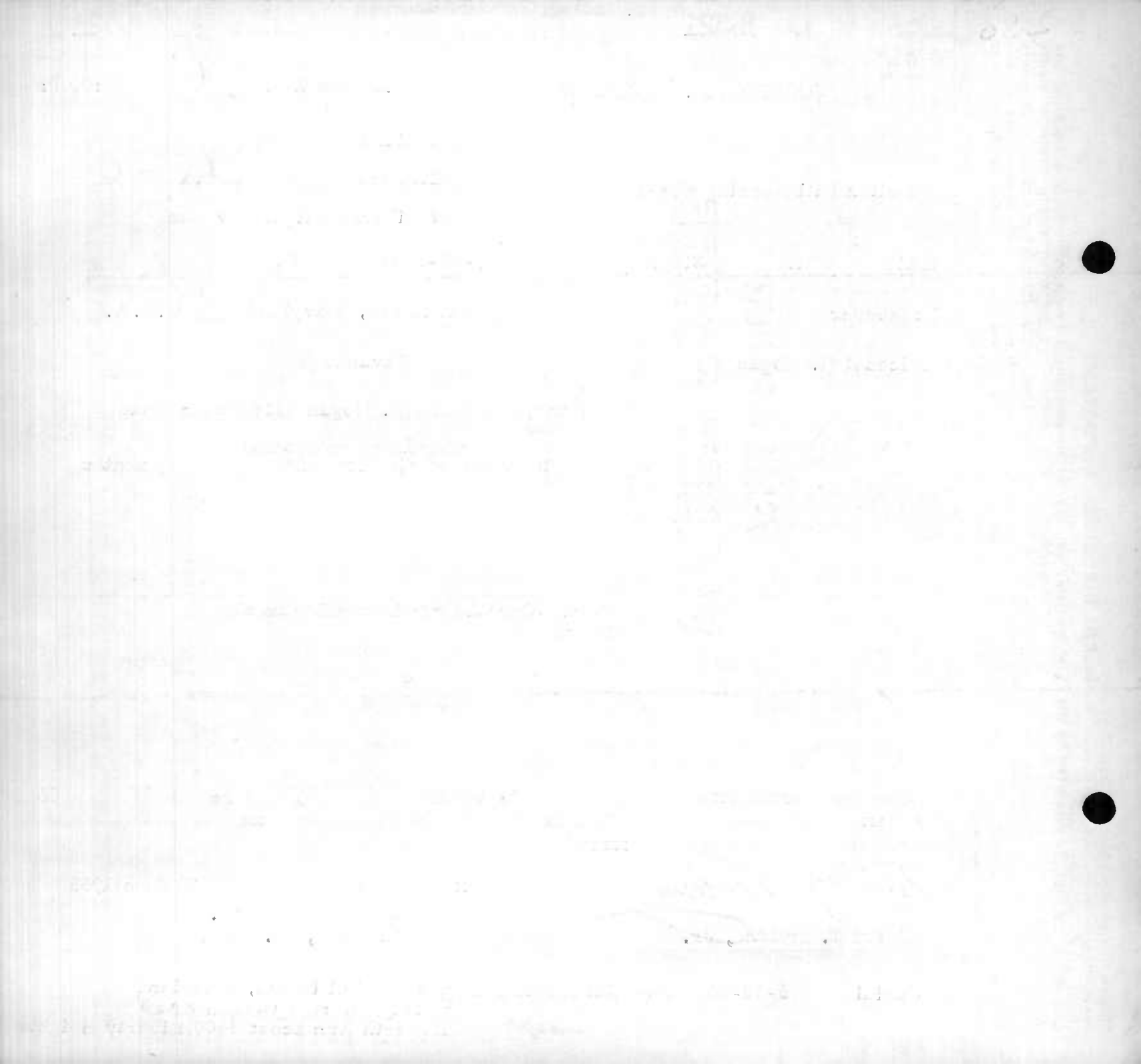
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 6 06520				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 06520	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
John Walker Rodgers				June 27, 1966 6:30 P: M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
5103 Gwynn Oak Avenue				Maryland			
5103 Gwynn Oak Avenue				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
5103 Gwynn Oak Avenue				Baltimore			
5103 Gwynn Oak Avenue				D. STREET ADDRESS (If rural, give location)			
5103 Gwynn Oak Avenue				5103 Gwynn Oak Avenue			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		White		Married		9-8-1887	
Male		White		Married		78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Bookeeper						Ireland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles H. Rodgers				Boyle			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				215-05-8682		Cora R. Rodgers 5103 Gwynn Oak Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) Coronary Occlusion			
ANTECEDENT CAUSES				DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Arteriosclerotic cardiovascular disease			
II				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				10 hours			
Gout, Generalized hypertrophic arthrititis				10 years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (the undersigned) attended the deceased from 19 60 to June 19 66, that (I) (we) lost saw the deceased alive on June 24, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Millard T. Traband, Jr.						28 June 1966	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
Millard T. Traband, Jr.						5101 Gwynn Oak Ave. Baltimore, Md. 21207	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-30-66		Western Cemetery		Baltimore, Md.	
25A. DATE REC'D. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR'S ADDRESS			
JUN 28 1966		Robert E. Farley		Ellsworth Armacost 4600 Liberty Heights.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06521	
BIRTH NO. 66 06521		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JOSEPH M. HOGAN		27 June 1966 8:00 P: M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Bolton Hill Nursing Home		Maryland			
90		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		4907 Liberty Heights Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	White	Single	9-30-1881	84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Bookkeeper				Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Michael H. Hogan		Cavanaugh		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		None		Edward F. Hogan 4019 Essex Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
163X I		generalized metastases		3 months	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II		Arteriosclerotic cardiovascular renal disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (Myself) attended the deceased from September 19 65 to June 19 66, that (I) last saw the deceased alive on 25 June 19 66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Millard T. Traband, Jr.				28 June 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Millard T. Traband, Jr.		5101 Gwynn Oak Ave. Baltimore, Md. 21207			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	6-30-66	New Cathedral Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR'S ADDRESS	
JUN 28 1966		Robert E. Farkas		Ellsworth Armacost 4600 Liberty Heights	



FUNERAL DIRECTOR: IMPORTANT

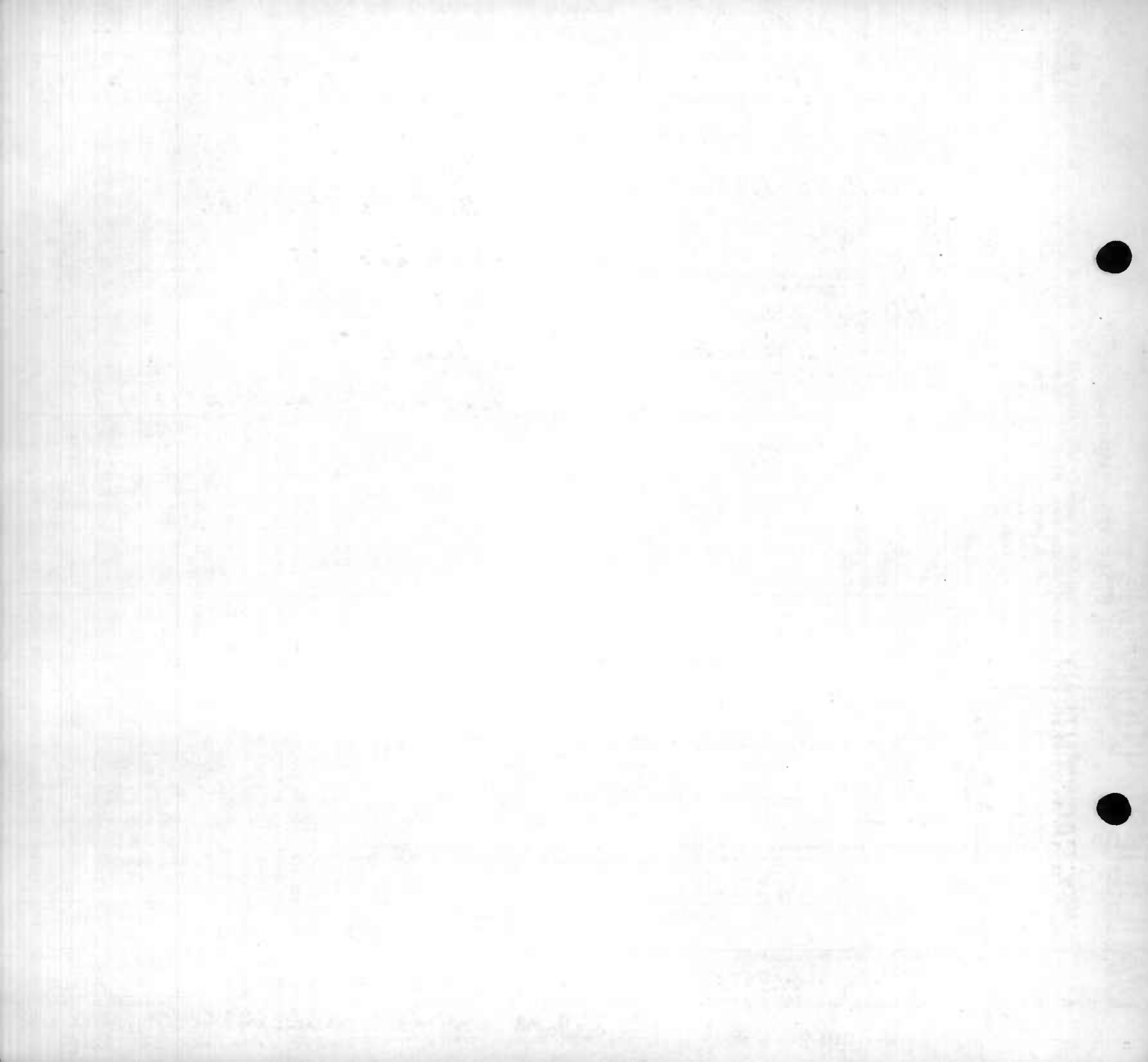
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06522		CERTIFICATE OF DEATH		Registered No. 66 06522	
1. NAME OF DECEASED (Type or Print) <u>Berkley J. Clemons</u>				2. DATE AND HOUR OF DEATH <u>June 26, 1966</u> <u>3:35 P.</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u> (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>16-07</u> D. STREET ADDRESS (If rural, give location) <u>2921 Ellicott Drive 21216</u>					
5. SEX <u>Female</u>	6. RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8-28-38</u>	9. AGE (In years last birthday) <u>27</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales girl</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Silber's Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Bell</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Bell</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>227-50-3850</u>		17. INFORMANT <u>Ethel Bell</u>		ADDRESS <u>2921 Ellicott Dr</u>	
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Intracerebral Hemorrhage</u> DUE TO (B) <u>Cerebro-vascular Accident</u> DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>June 24, 1966</u> to <u>June 26, 1966</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>June 26, 1966</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.									
23A. SIGNATURE <u>Desideria T. Mahusay</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>6-26-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DESIDERIA T. MAHUSAY</u>				23D. ADDRESS M.D. <u>Lutheran Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/30/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1966</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Herbert E. Nutter-3035 W. North Ave.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
3912 Norfolk Avenue		Maryland Baltimore		15-07	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Female		Colored		Married	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Aug 14, 1886		79		Housewife	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Baltimore, Md.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Aaron Glover		Adell ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Mrs. Hester Beale	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
CVA		Arteriosclerosis		2 Weeks	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
Malnutrition					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-15-1966 to 6-21-1966, that (I) (we) last saw the deceased alive on 6-20-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
E. C. CLAY				6-23-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
E. C. CLAY		3405 GARRISON BLVD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/25/66		Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Brooklyn		Joseph L. House		2222 W. North Ave	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
		Robert E. Jenkins		Joseph L. House	
JUN 28 1966				Baltimore, Md.	



Released by Medical Examiner in approval of CP

FUNERAL DIRECTOR: IMPORTANT

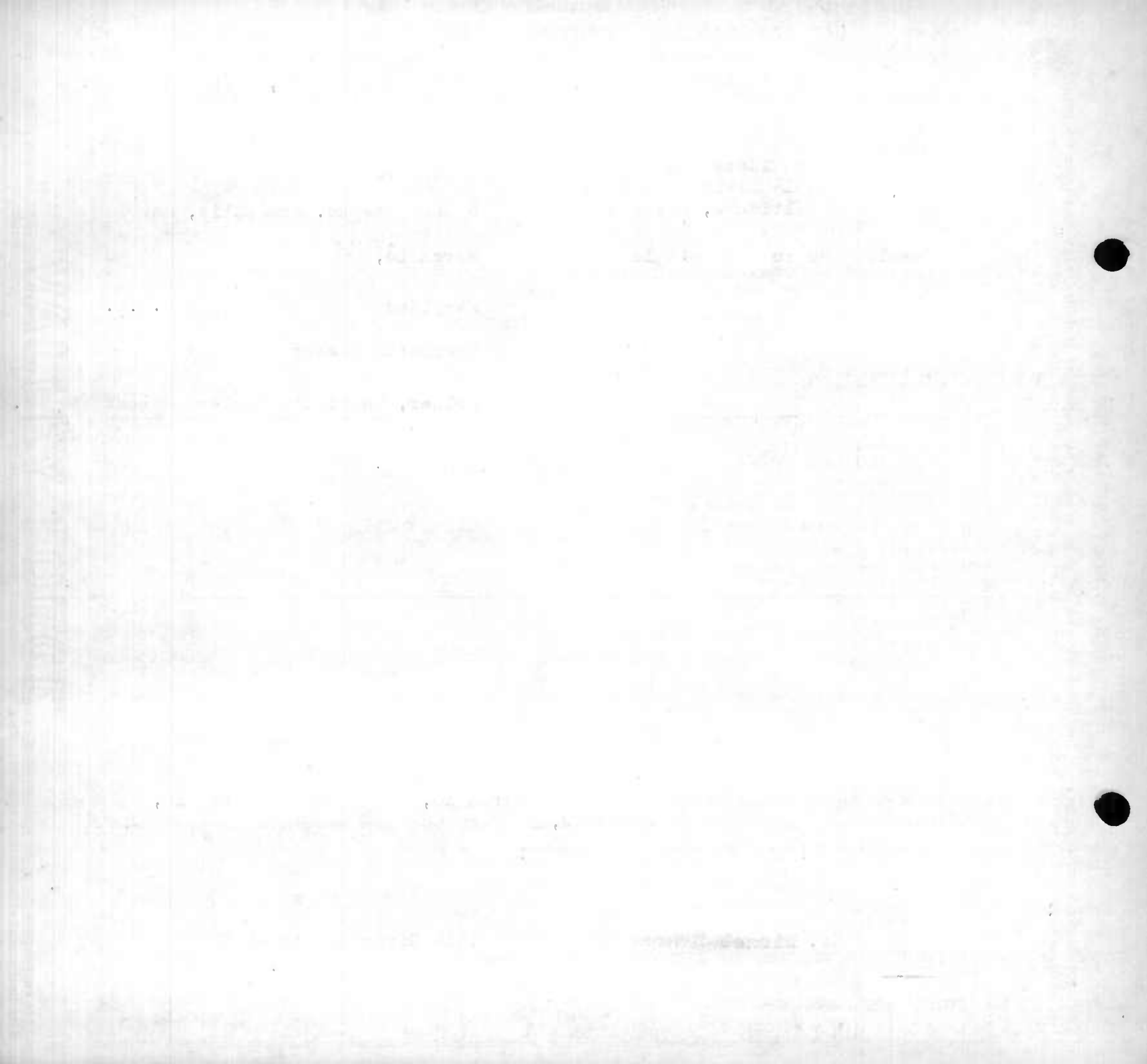
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No.	
BIRTH NO. 66 06524										66 06524	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Eleanor V. Gosnell</i>						2. DATE AND HOUR OF DEATH <i>June 27, 1966</i> <i>5:25p.m.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>91 Montebello State Hospital</i>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>P.G.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Hyattsville</i> <i>66-00</i> D. STREET ADDRESS (If rural, give location) <i>8402 14th Ave.</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED (<input checked="" type="checkbox"/> WIDOWED) <input type="checkbox"/> DIVORCED (specify)		8. DATE OF BIRTH <i>2-24-81</i>	9. AGE (In years last birthday) <i>85</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>James Harrison</i>				14. MOTHER'S MAIDEN NAME <i>Laura</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Hospital Chaut</i>		ADDRESS			
18. <i>332X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH <i>Right Cerebral Thrombosis with Left Hemiplegia</i> <i>Anteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>unknown</i>		
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes (partial)</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <i>June 23, 1966</i> to <i>June 27, 1966</i> , that (I) (we) last saw the deceased alive on <i>June 27, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Cesar J. Pellenano</i>				M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>June 27, 1966</i>					
23C. PHYSICIAN'S NAME (Type) <i>Cesar J. Pellenano</i>				23D. ADDRESS <i>Montebello Hospital</i>							
24A. BURIAL CREMATION, REMQVA (Specify) <i>Burial</i>		24B. DATE <i>6/30/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Fort Lincoln Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Prince Georges County Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 28 1966</i>		25B. NAME OF REGISTRAR <i>P. E. E. Farley, MA</i>		25C. FUNERAL DIRECTOR <i>Arthur Walter Washington, D.C.</i>							

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-05943 66 06525		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06525	
1. NAME OF DECEASED (Type or Print) Baby of Henrietta Tasker			2. DATE AND HOUR OF DEATH March 10, 1966 9:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY AA C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 52-10 6 Bestgate Rd. Annapolis, Maryland		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH March 10, 1966	9. AGE (In years lost birthday) 6	If Under 1 Yr. Months: Days: Hours: Min. 6 27
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Henrietta Tasker		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mother, Henrietta Tasker 6 Bestgate Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 762.5 I Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Primarily Heart DUE TO arise (B) Immaturity DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from March 10, 1966 to March 10, 1966 , that (I) (we) last saw the deceased alive on March 10, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lionel C. Rose			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) Dr. Lionel Rose			23D. ADDRESS M.D. 1514 Division Street		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. 66 06526	
BIRTH NO. 66 06526											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) HAROLD JOSEPH YOUNG					2. DATE AND HOUR OF DEATH June 26, 1966 9:15 a. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3703 Elmley Ave. Baltimore, Md. 21213					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3703 Elmley Ave.						
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 1/13/1918	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: Hours: Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer			10B. KIND OF BUSINESS OR INDUSTRY Fleet McKinley & Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Clarence Young					14. MOTHER'S MAIDEN NAME Elizabeth Tonroe						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 213-03-3779		17. INFORMANT ADDRESS Anna Fleischman Young, wife, above						
18. 191-3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH			
					(A) Aspiration - angina DUE TO			30 mi			
			(B) Esophageal Carcinoma of Face DUE TO			6 yrs					
			(C)								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 1941-1942			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Face			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from January 1959 to 1965 that (I) (we) lost saw the deceased alive on October 20 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE James K. Hensley					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED June 27, 1966			
23C. PHYSICIAN'S NAME (Type) Dr. James K. Hensley					23D. ADDRESS 2200 Mayfield Ave.						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/66		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966			25B. NAME OF REGISTRAR Robert E. Hensley			25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.				ADDRESS 3331 Brehms Lane	

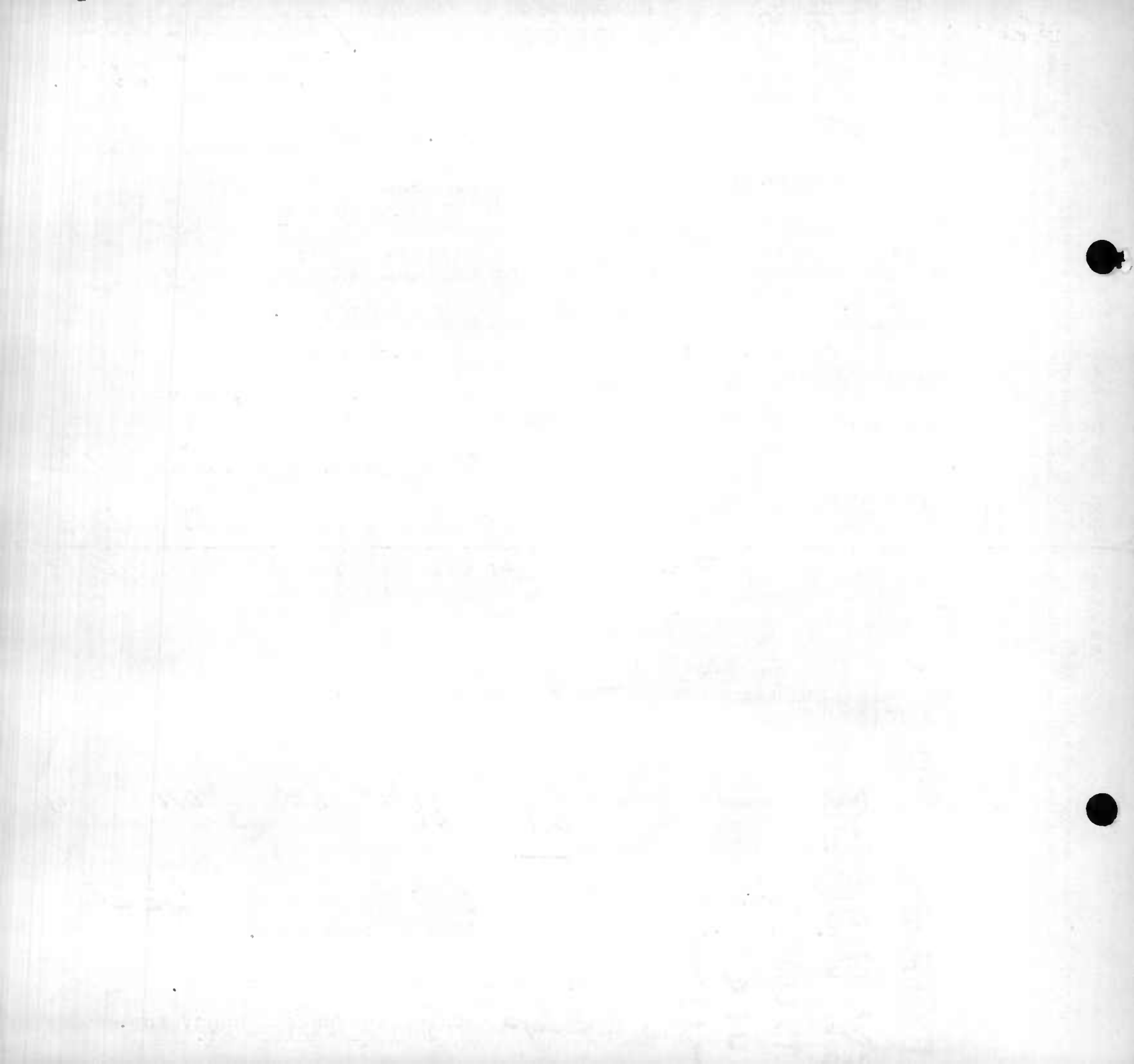
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06527	
BIRTH NO. 66 06527		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MABEL GERTRUDE GUMPMAN		2. DATE AND HOUR OF DEATH June 26, 1966 1:10 a. m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harford Gardens Conv. Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 21206 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-02 D. STREET ADDRESS (If rural, give location) 4620 Kavon Ave.			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 5/16/1885	9. AGE (In years lost birthday) 81	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME James P. Coleman		14. MOTHER'S MAIDEN NAME Emma Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-22-6072		17. INFORMANT Carroll Clifton Gumpman, son, above	
18. 4-22-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Arteriosclerotic Cardio Vascular disease</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 19 64 to June 26 19 66, that (I) (we) lost saw the deceased alive on 5 / 12 / 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Paul G. Mueller</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 6/27/66	
23C. PHYSICIAN'S NAME (Type) Dr. Paul G. Mueller		23D. ADDRESS 6411 Belair Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/66		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Paul G. Mueller</i>		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

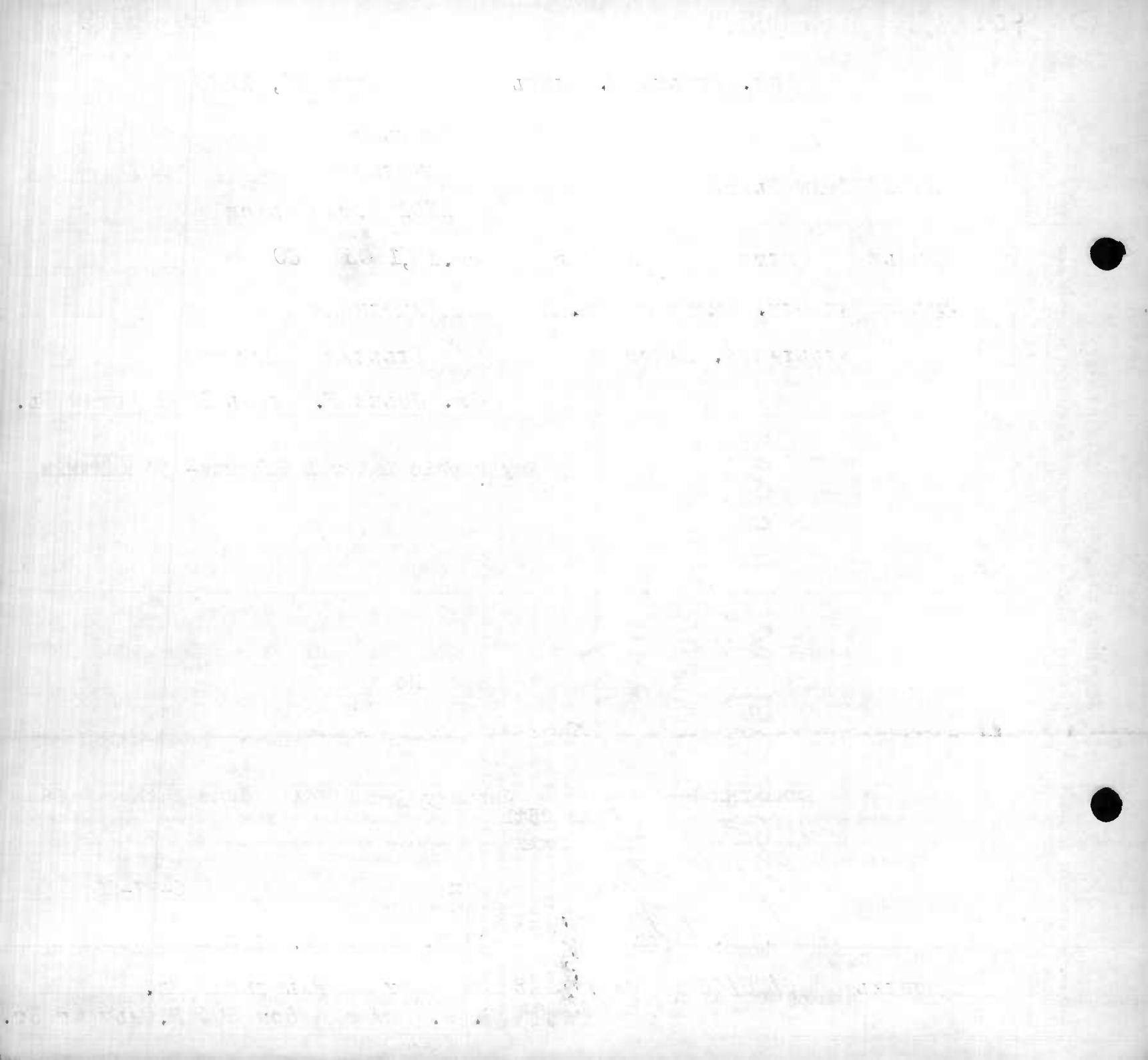
BIRTH NO. 66 06528		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06528	
1. NAME OF DECEASED (Type or Print) ELENORA ANNA KLIMA				2. DATE AND HOUR OF DEATH June 25, 1966 6:30 p. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION City Hospital (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md., B. COUNTY 21222 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk D. STREET ADDRESS (If rural, give location) 7619 Cedar Road			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 2/21/1899	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Kubin				14. MOTHER'S MAIDEN NAME unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT John Klima, husband, above		ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) myocardial infarction DUE TO (B) ischemic heart disease DUE TO (C) Coronary A.S.		INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years 10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/21 1963 to 6/6 1966 , that (I) (we) lost saw the deceased alive on 6/6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. H. Kolodny M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/27/66	
23C. PHYSICIAN'S NAME (Type) Dr. Lewis A. Kolodny		23D. ADDRESS 1825 Eastern Blvd.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/66		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

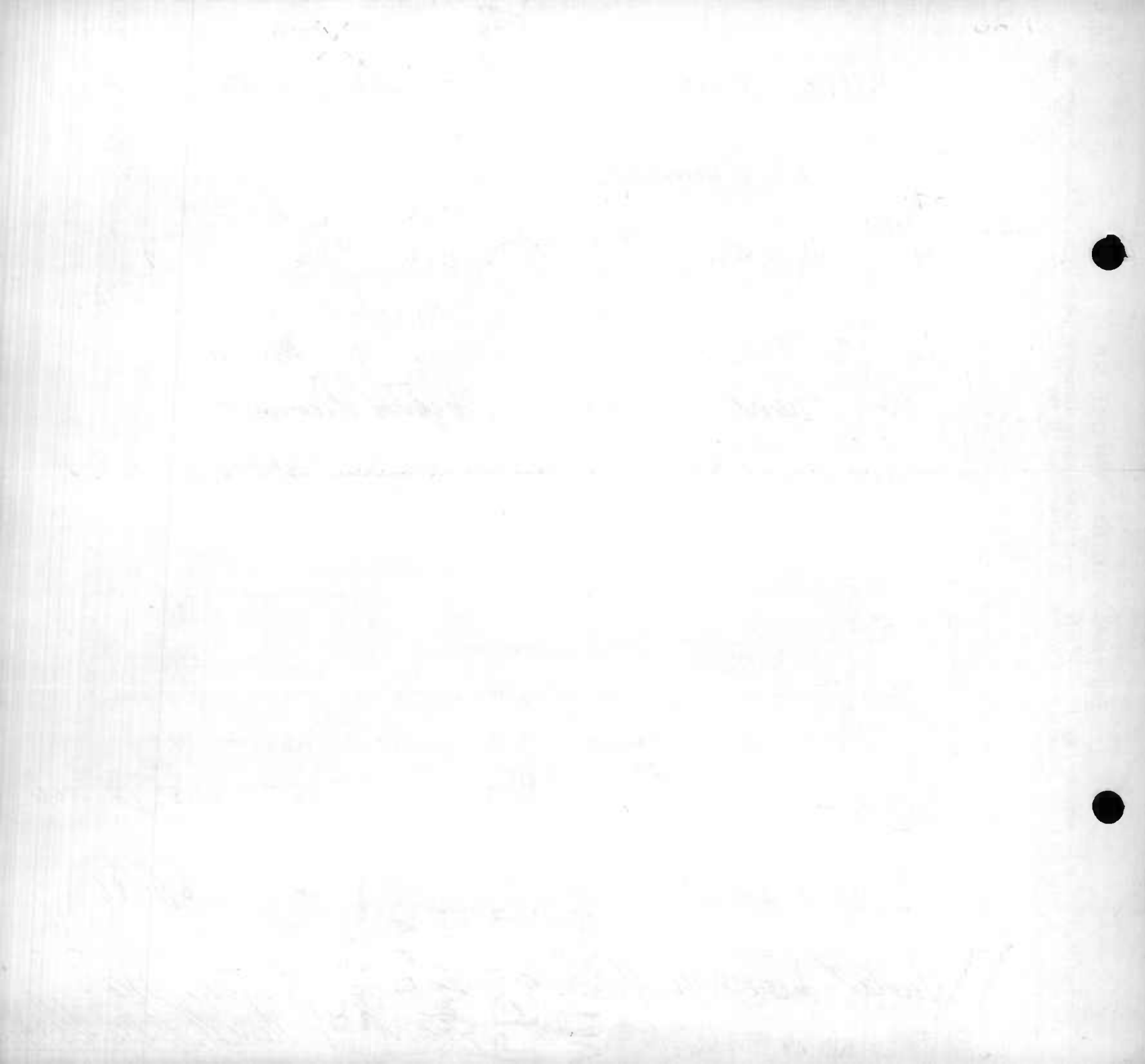
BIRTH NO. 66 06529				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06529	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Mrs. EVELYN M. DIEHL				JUNE 26, 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
1701 EUTAW PLACE				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE 14-01			
				D. STREET ADDRESS (If rural, give location)			
				1701 EUTAW PLACE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		
FEMALE	WHITE	MARRIED	OCT. 10, 1905	60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
SALES TAX DIV. STATE OF MD.			BALTIMORE				
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
WILLIAM A. MAHON			LILLIAN JACKSON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
					MR. JULES F. DIEHL 1701 EUTAW PL.		
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				30 months			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) Amyotrophic Lateral Sclerosis			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) observed attended the deceased from January 3rd 1964 to June 26th 1966, that (I) (we) last saw the deceased alive on June 25th 1966 and that in (my) xxx opinion death occurred on the date and hour and from the causes stated above, (I) xxx (did) xxx view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Philip D. Flynn						6-27-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Philip D. Flynn				11 E. Chase St. 21202			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		6/29/66		CATHEDRAL CEMETERY		BALTIMORE MD.	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
6/29/66		Robert E. Jackson		H. W. MEARS & SON 805 N. CALVERT ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06530	
BIRTH NO. 66 06530		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KEITH ZILKA		2. DATE AND HOUR OF DEATH 6/18/66 2:44 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balto		5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		6. STREET ADDRESS (If rural, give location) 1001 Perine Lane			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 6/11/66	9. AGE (In years last birthday) 1	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Leo E. Zilka		14. MOTHER'S MAIDEN NAME Mary M. Devine		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Records -	
18. 773.01		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 11 days	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Respiratory Distress Syndrome known: Probable obstructive jaundice			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 11 1966 to June 18 1966 , that (I) (we) last saw the deceased alive on June 18 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Smello B. Salario		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/18/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE June 20 1966		24C. NAME OF CEMETERY or CREMATORY Random of Faith Cemetery Baltimore, Md.	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR Robert E. Jackson	
24G. FUNERAL DIRECTOR Frank H. Newell, President		24H. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06531	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 66 06531 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ANDREWS, MISS GRACE Lee			2. DATE AND HOUR OF DEATH 6-25-66 11:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Keswick Home for Incurables 700 W 40th Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 700 W 40th Street		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 2-5-86	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? Yes U.S.A			13. FATHER'S NAME Charles W. Andrews		
14. MOTHER'S MAIDEN NAME Ida Smith			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 218-52-0767			17. INFORMANT ADDRESS Mary E Wharton (Records) 700 W 40th Street		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) DUE TO Hypertensive Cardio-vascular Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. INTERVAL BETWEEN ONSET AND DEATH 5 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 21 1962 to June 25 1966, that (I) (we) last saw the deceased alive on June 24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Giffon Hersperger M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED June 25, 1962		
23C. PHYSICIAN'S NAME (Type) W. Giffon Hersperger M.D.			23D. ADDRESS 700 West 40th Street.		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/1966		24C. NAME OF CEMETERY or CREMATORY Lorraine	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966			
25B. NAME OF REGISTRAR Robert E. Fairley, Jr.		25C. FUNERAL DIRECTOR ADDRESS Harry H. Harns 4204 Ridgewood Ave. Baltimore, Md. 21215			

WILFRED BOWEN

THE 1914-1915 YEAR
of the 1914-1915 YEAR

66 06532

BALTIMORE CITY HEALTH DEPARTMENT

66 06532

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Alexander KUCHARCZYK

2. DATE AND HOUR PRONOUNCED DEAD

June 24, 1966 2:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

8/17/66

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2530 Foster Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug. 13, 1926

9. AGE (In years
lost birthday)

40 39

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

Edw. Kreller

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Joseph Kucharczyk

14. MOTHER'S MAIDEN NAME

Josephine Bednarczyk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-18-7455

17. INFORMANT

Mrs. Josephine Kucharczyk 2530 Foster Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Cranio - cerebral injury

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office, bldg,
etc.)

Acme Market

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?Longmeadow Shopping Center,
Hagerstown, Maryland, Intersection of
Fleet & Bond Streets21D. TIME (Month) (Day) (Year) (Hour) (Minute)
(APPROX.)

June 21, 1966 12:20

21E. INJURY OCCURRED
WHILE AT WORK ☒ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Fell

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

R. Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 25, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

June 28, 1966

23C. NAME of CEMETERY or CREMATORY

Holy Rosary Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 29 1966

24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

Raymond L. Kaczorowski 2525 Fleet St.

ADDRESS

Letter dated 8/15/66 from Dr. Rudiger Preitnecker, Asst/ME

Dr. Preitnecker - 8/15/66

CAR 4

1
L-246

66 06533

BALTIMORE CITY HEALTH DEPARTMENT

66 06533

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Isham LOCKLEAR

2. DATE AND HOUR PRONOUNCED DEAD

6/26/66

1:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)
33
99
Church Home Hospital (DOA)4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

623 S. Patterson Park Avenue

5. SEX

Male

6. RACE

Am. Indian
-White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 4, 1935

9. AGE (In years
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Chevrolet

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Locklear

14. MOTHER'S MAIDEN NAME

Maggie Locklear

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
240-46-0216

17. INFORMANT

ADDRESS

Mr. Geo. W. Smith 623 S. Patterson Park Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cranio-cerebral injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Patterson Park at Eastern

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 26 66 12:45

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Motorcycle - auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

R. Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
June 26, 196623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 3, 1966

23C. NAME of CEMETERY or CREMATORY

Prospect Cemetery

23D. LOCATION

(City, town, or county)

Maxton, North Carolina

24A. DATE REC'D BY HEALTH DEPT.

JUN 29 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Raymond L. Kaczorowski 2525 Fleet Balto.Md.

Letter from Breitnecker-7/15/66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06534	
BIRTH NO. 66 06534		CERTIFICATE OF DEATH	
M.E. CASE NO.		DATE AND HOUR OF DEATH 6/27/66 3:45 P.M.	
1. NAME OF DECEASED (Type or Print) JOSEPH A SIMONS		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Balto. Maryland 21224		A. STATE MARYLAND B. COUNTY BALTIMORE	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) DUNDALK 5300	
5. SEX Male 6. RACE White		D. STREET ADDRESS (If rural, give location) 3412 CORNWALL ROAD = 21222	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 3-13-88 9. AGE (In years lost birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY AUTOMOTIVE	
11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MANUEL - DECEASED		14. MOTHER'S MAIDEN NAME MARTHA - DECEASED	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 021-09-7842	
17. INFORMANT RECORDS: BCH 4940 Eastern Ave, Balto. Md. 21224		ADDRESS	
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 6/27 1966 to 6/27 1966 , that (I) (we) last saw the deceased alive on 6/27 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Ben F. Hughes		23B. DATE SIGNED 6/27/66	
23C. PHYSICIAN'S NAME (Type) BENJAMIN F. HUGHES		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Balto. Md 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/30/66	
24C. NAME OF CEMETERY or CREMATORY SACRED HEART SESOS		24D. LOCATION (City, town, or county) (State) BALTO. CO., MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR McCrackin Proffitt, Dundalk, Md.		ADDRESS	

2-22-88

GRANTING CITY HOSPITAL

M. W. 3-13-88 18

GRANTING CITY HOSPITAL

Microscopic Examination

4/21/88

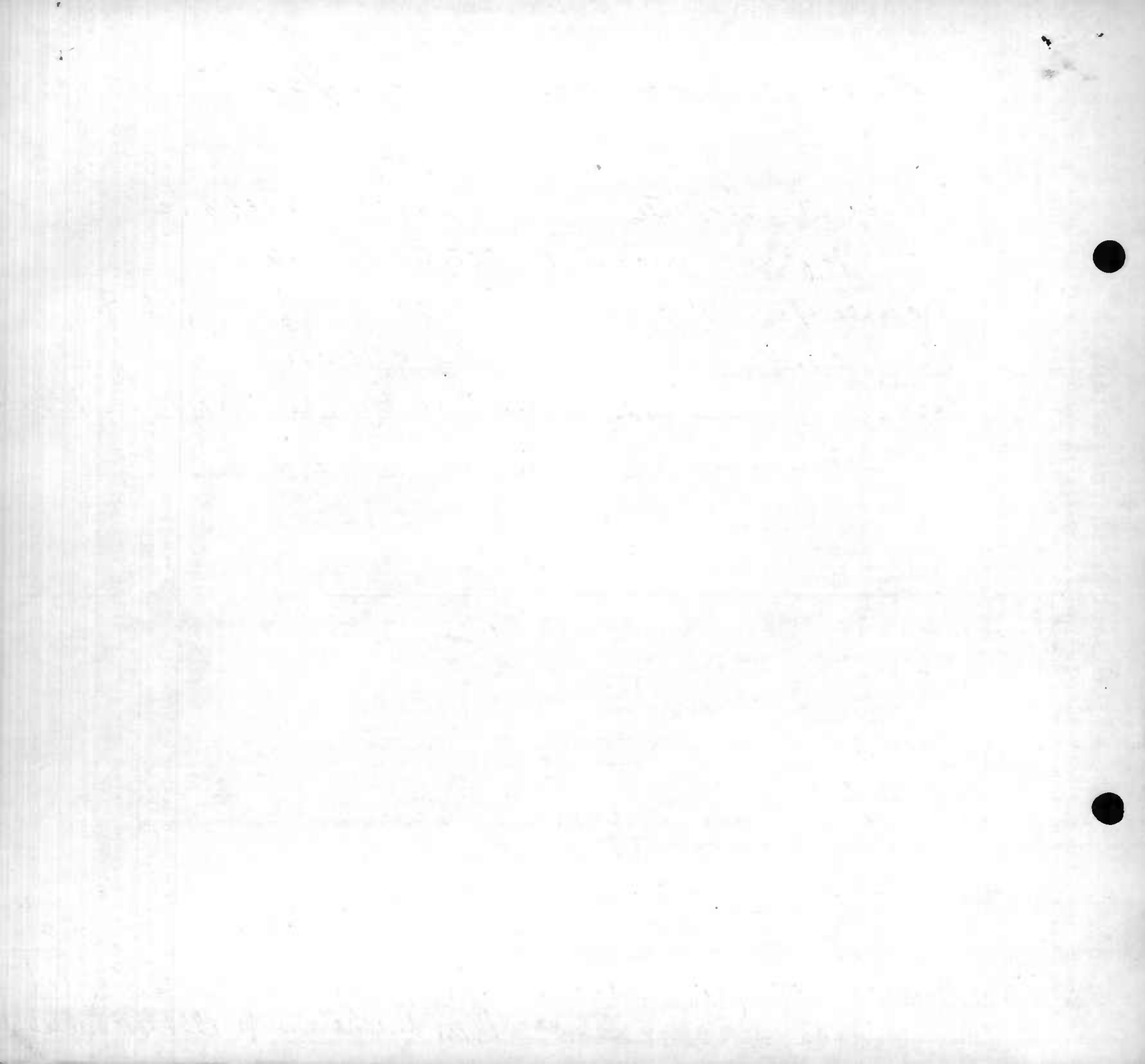
Bert. H. H.

Examine slide from tissue from patient with
diagnosis of Microscopic Examination

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06535	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) EDNA G. BARBEE				2. DATE AND HOUR OF DEATH 6/20/66 5:11 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE md. 8. COUNTY Balto.			
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. 15-05			
				D. STREET ADDRESS (If rural, give location) 3221 Burleigh Ave.			
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Oct. 5, 1901	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) md		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wm. Foote				14. MOTHER'S MAIDEN NAME Shaeckel			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-30-4122		17. INFORMANT Thero Smith		ADDRESS 3221 Burleigh Ave	
18. 4-20-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC HEART DISEASE				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. ARTERIOSCLEROSIS				SENILITY			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Myocardial Failure							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-14 66 to 6-25 66 , that (I) (we) last saw the deceased alive on 4/25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. L. Banfield				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/27/66	
23C. PHYSICIAN'S NAME (Type) E. L. BANFIELD				23D. ADDRESS 722 N. Fulton Ave Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/66		24C. NAME OF CEMETERY or CREMATORY Pleasant Rest		24D. LOCATION (City, town, or county) (State) Towson, Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Wm. J. Chaturan		ADDRESS 1701 W. Culloden St	



66 06536

BALTIMORE CITY HEALTH DEPARTMENT

66 06536

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Elmer Keckler

2. DATE AND HOUR PRONOUNCED DEAD

June 22, 1966

4:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

611 South Hanover Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore,

D. STREET ADDRESS (If rural, give location)

611 South Hanover Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SEAMAN

10B. KIND OF BUSINESS OR INDUSTRY

SHIPPING

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

165 12 4559 Mrs. Mary Embert 112 Warren Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Diabetes mellitus

(A) _____
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

R. Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 23, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/28/66

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 29 1966

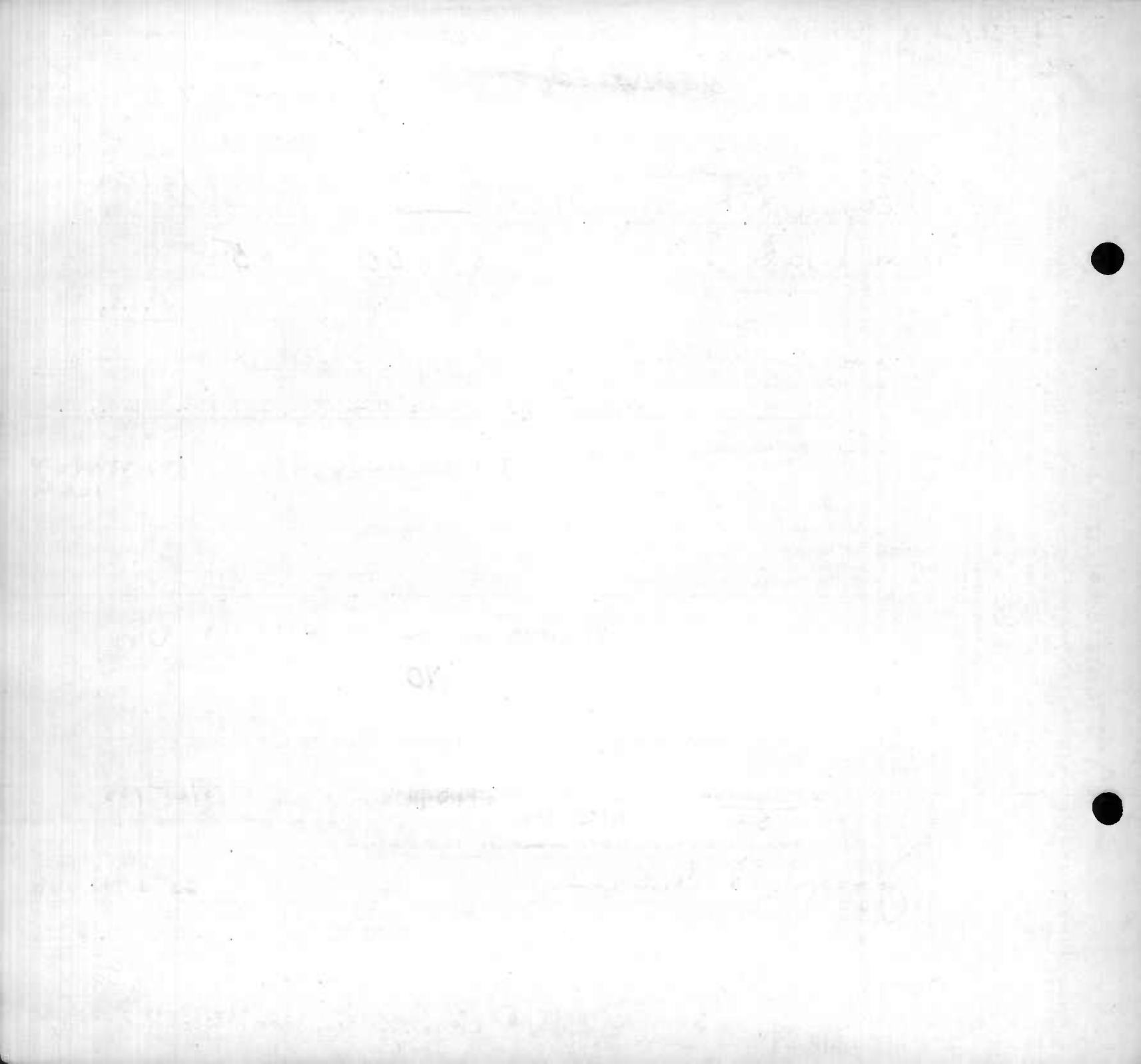
Robert E. Farkas

JOHN F. DENNY, INC. 715 Light St

FUNERAL DIRECTOR: IMPORTANT

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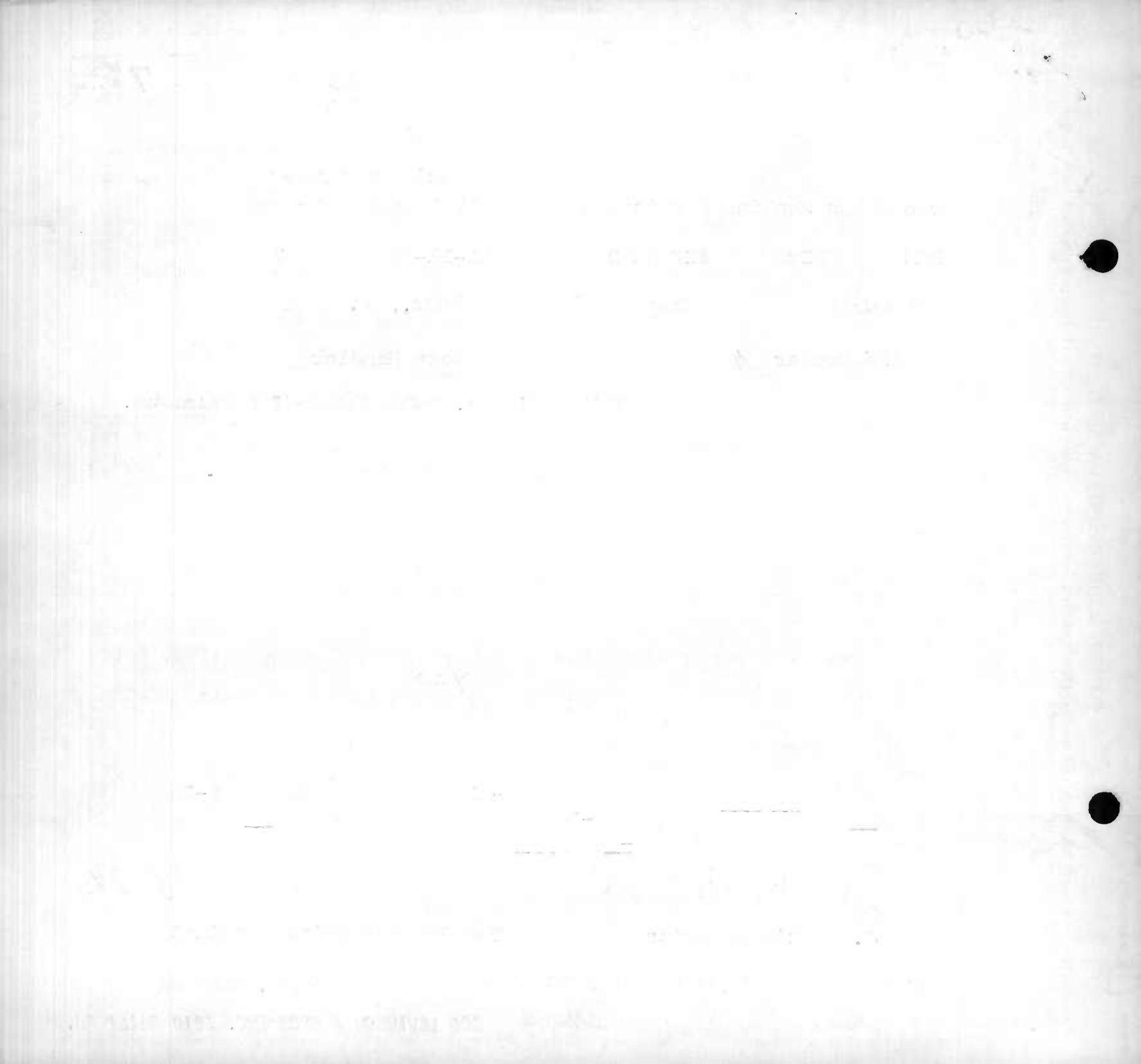
BIRTH NO. 66 06537		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06537	
M.E. CASE NO. PHILIP J		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH June 25 - 1966 7:45 P.M.	
1. NAME OF DECEASED (Type or Print) Phillip DELLAVEGUE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE MD. COUNTY BALTO.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 21221, Md.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location)		8-29-97 35 BACK RIVER NECK ROAD	
644 Tuberculosis Baltimore City Hospital 4940 EASTERN AVE. BALTIMORE, MD. 21224		8. DATE OF BIRTH		9. AGE (In years last birthday) 65	
6. SEX Male 6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10A. USUAL OCCUPATION		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CANADA	
13. FATHER'S NAME Prosper (PROSPER)		14. MOTHER'S MAIDEN NAME Anna Packett (ANNA PACKETT)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-05-7012		17. INFORMANT ADDRESS #21224 RECORDS: BCH-4940 EASTERN AVE. BALTO., MD.	
18. 002-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) TUBERCULOSIS DUE TO		INTERVAL BETWEEN ONSET AND DEATH MONTHS 10 YEARS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		PNEUMOCOCCAL PNEUMONIA DAYS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6/15/66 19 to 6/25/66 19 that (I) (we) last saw the deceased alive on 6/15/66 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph I Berman M.D.		23B. DATE SIGNED 25 June 66			
23C. PHYSICIAN'S NAME (Type) JOSEPH I BERMAN M.D.		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO., MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/66		24C. NAME OF CEMETERY or CREMATORY Sacred Heart	
24D. LOCATION Balto. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farkus		25C. FUNERAL DIRECTOR Connelly Sons 300 Mace Ave. Balto. 21	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

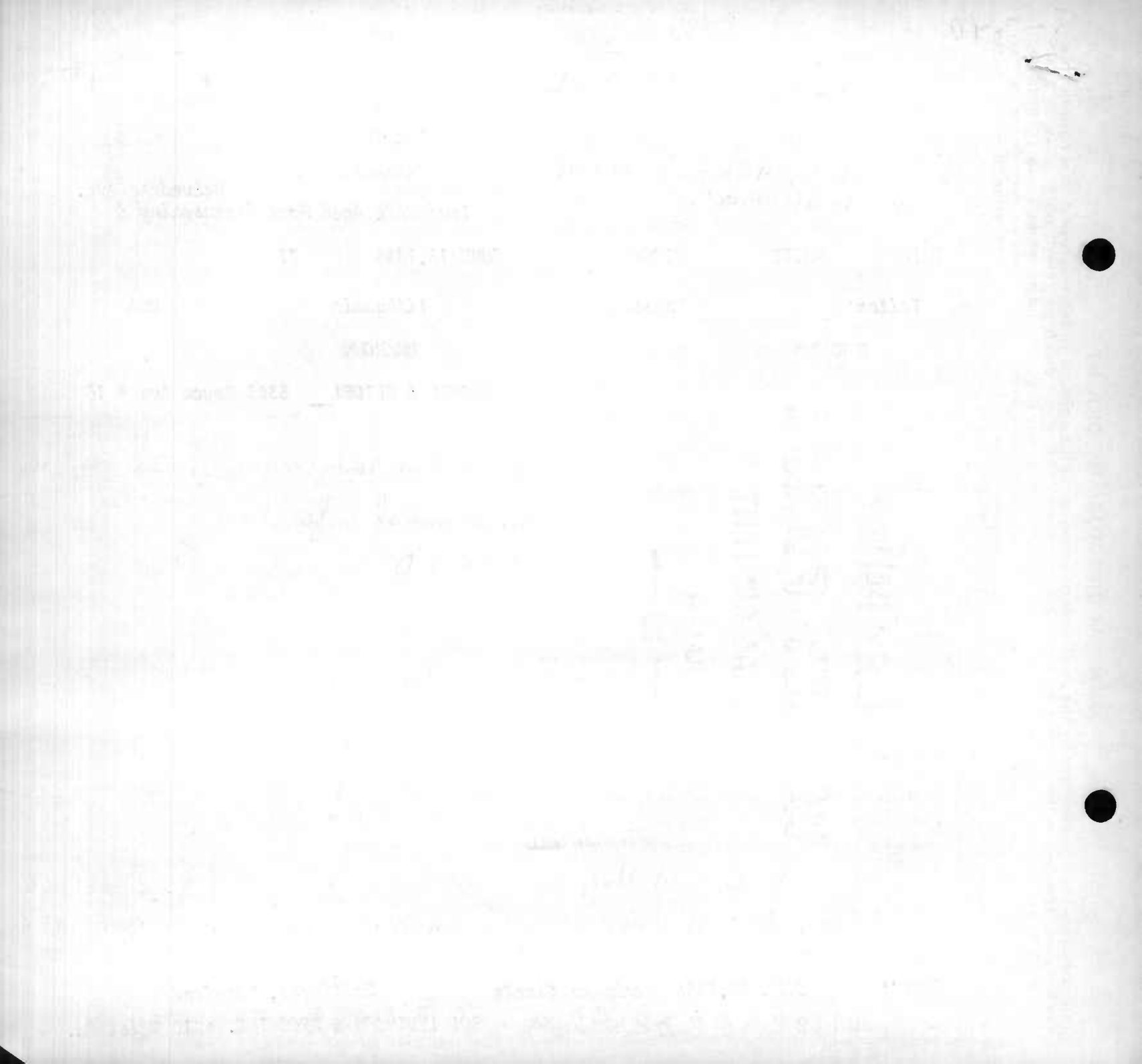
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06538	
BIRTH NO. 66 06538		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DAVID HECKER		2. DATE AND HOUR OF DEATH 6-28-66 7:45 am M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital n		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 21209 C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-20 D. STREET ADDRESS (If rural, give location) 2707 Hanson Avenue			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 12-31-98	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10B. KIND OF BUSINESS OR INDUSTRY Drug		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Louise Hecker		14. MOTHER'S MAIDEN NAME Dora Hendler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579/26/2821		17. INFORMANT Mr. Nathan Hecker-2707 Hanson Ave.	
18. I 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Co prostate DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 7 yrs.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-13 19 66 to 6-28 19 66 that (I) (we) last saw the deceased alive on 6-28 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-28	
23C. PHYSICIAN'S NAME (Type) J. Martin Lebowitz		23D. ADDRESS M.D. The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUNE 29, 1966		24C. NAME OF CEMETERY or CREMATORY Hebrew Friendship	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966			
25B. NAME OF REGISTRAR Robert E. Gaskins		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS INC. 6010 Reist Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06539	
<div> <div>IRTH NO. 66 06539</div> <div>CERTIFICATE OF DEATH</div> </div>					
<div> <div>M.E. CASE NO.</div> <div>1. NAME OF DECEASED (Type or Print) ISAAC SEIDEL</div> </div>			<div> <div>2. DATE AND HOUR OF DEATH</div> <div>6-28-1966 140 a.m.</div> </div>		
<div> <div>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</div> <div> <div>FULL NAME OF HOSPITAL OR INSTITUTION</div> <div>LEVINDALE, HEBREW HOME AND INFIRMARY</div> </div> </div>			<div> <div>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</div> <div> <div>A. STATE Maryland</div> <div>B. COUNTY Baltimore</div> </div> </div>		
<div> <div>5. SEX MALE</div> <div>6. RACE WHITE</div> <div>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW</div> </div>			<div> <div>8. DATE OF BIRTH JUNE 16, 1889</div> <div>9. AGE (In years lost birthday) 77</div> </div>		
<div> <div>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor</div> <div>10B. KIND OF BUSINESS OR INDUSTRY Presser</div> </div>		<div> <div>11. BIRTHPLACE (State or foreign country) Lithuania</div> <div>12. CITIZEN OF WHAT COUNTRY? USA</div> </div>			
<div> <div>13. FATHER'S NAME UNKNOWN</div> <div>14. MOTHER'S MAIDEN NAME UNKNOWN</div> </div>			<div> <div>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div>16. SOCIAL SECURITY NO.</div> <div>17. INFORMANT ARCHIE A SEIDEL ADDRESS 3303 Royce Ave # 15</div> </div>		
<div> <div>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div>4-20-1 I</div> <div>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</div> <div>ANTECEDENT CAUSES</div> <div>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> </div>			<div> <div>CAUSE OF DEATH</div> <div>(A) ventricular tachycardia</div> <div>(B) myocardial infarction</div> <div>(C) ASCVD</div> </div>		
<div> <div>18. INTERVAL BETWEEN ONSET AND DEATH</div> <div>30 minutes</div> </div>			<div> <div>II</div> <div>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</div> </div>		
<div> <div>19A. DATE OF OPERATION</div> <div>0</div> </div>		<div> <div>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div> </div>		<div> <div>20A. AUTOPSY? (Yes or No) No</div> <div>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div> </div>	
<div> <div>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</div> <div>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div> </div>		<div> <div>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div> </div>		<div> <div>21D. TIME OF INJURY (APPROX.)</div> <div>21E. HOW DID INJURY OCCUR?</div> </div>	
<div> <div>22. I certify that (I) (this hospital) attended the deceased from July 17 1961 to June 28 1966, that (I) (we) last saw the deceased alive on June 28 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div> </div>		<div> <div>23A. SIGNATURE Ruth Willner M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></div> <div>23B. DATE SIGNED June 28, 66</div> </div>			
<div> <div>23C. PHYSICIAN'S NAME (Type) Ruth Willner</div> <div>23D. ADDRESS LEVINDALE, HEBREW HOME AND INFIRMARY</div> </div>		<div> <div>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</div> <div>24B. DATE JUNE 29, 1966</div> <div>24C. NAME OF CEMETERY or CREMATORY Workmens Circle</div> <div>24D. LOCATION (City, town, or county) Baltimore, Maryland</div> </div>			
<div> <div>25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966</div> <div>25B. NAME OF REGISTRAR Robert E. Farley</div> </div>		<div> <div>25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS INC. 6010 Reist Rd.</div> </div>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06540				BALTIMORE CITY HEALTH DEPT.		Registered No. 66 06540	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Joseph Adams, Sr.				2. DATE AND HOUR OF DEATH June 27, 1966 9:10p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1113 N. Stockton Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH March 17, 1890	9. AGE (In years last birthday) 76	10. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Joseph Adams, Jr.-son		ADDRESS same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) Carcinoma of the lungs, terminal DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		21G. DATE OF OPERATION		21H. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22. I certify that (I) (this hospital) attended the deceased from June 27, 1966 to June 27, 1966, that (I) (we) last saw the deceased alive on June 27, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Andre' Rigaud				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 28, 1966	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. 1514 Division Street-Baltimore 17, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-66		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Arbutus Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR George G. Nelson		ADDRESS 1348 N. Calhoun St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06541				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06541	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BLAKELOYD, BENJAMIN				2. DATE AND HOUR OF DEATH June 25, 1966 11 30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 Franklin Square Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 23 19-02 D. STREET ADDRESS (If rural, give location) 204 N. Mount St.			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5-17-1895	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Jamaica B W I		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-36-9970		17. INFORMANT NENA FLACKS		ADDRESS 204 N. Mount St.	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Hypertensive arteriosclerotic (B) DUE TO Cardiovascular disease (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 25, 1966 to June 25, 1966 , that (I) (we) last saw the deceased alive on June 25, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jong-Hi Bek M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 25, 1966	
23C. PHYSICIAN'S NAME (Type) TONG-HI BEK M.D.				23D. ADDRESS Franklin Square Hospital, Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-66		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
66 06542					66 06542					
BIRTH NO.					REGISTERED NO.					
M.E. CASE NO.					CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH					
MABEL A. RICE					6-27-66 6:20 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			A. STATE		B. COUNTY			
ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTO. 29, MD.					MARYLAND		Anne Arundel			
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
					LINTHICUM 52-00					
					D. STREET ADDRESS (If rural, give location)					
					509 SHIPLEY ROAD					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		
FEMALE		WHITE		WIDOWED		12-12-96		69		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE			NONE			VIRGINIA			U.S.A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME				
AUSTIN MORRIS						CLEMENTINE SHIFFLETT				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Yes				216-31-8888		ST. AGNES HOSPITAL, WILKENS & CATON AVE.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)					(A) PULMONARY TUBERCULOSIS					
ANTECEDENT CAUSES					(B) PNEUMONIA					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)					
II					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 6/10 19 66 to 6/27 19 66, that (I) (we) last saw the deceased alive on 6/27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE						23B. DATE SIGNED				
MIGUEL A HEREDIA						6-27-66				
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS				
MIGUEL A HEREDIA						ST. AGNES HOSPITAL, WILKENS & CATON AVE.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)				
Burial		June 30, 1966		Glen Haven Mem. Park		Glen Burnie, Md.				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS				
JUN 29 1966		R. E. Farber		R. V. Singleton		Singleton Funeral Home Glen Burnie, Md.				

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ST. LOUIS HOSPITAL
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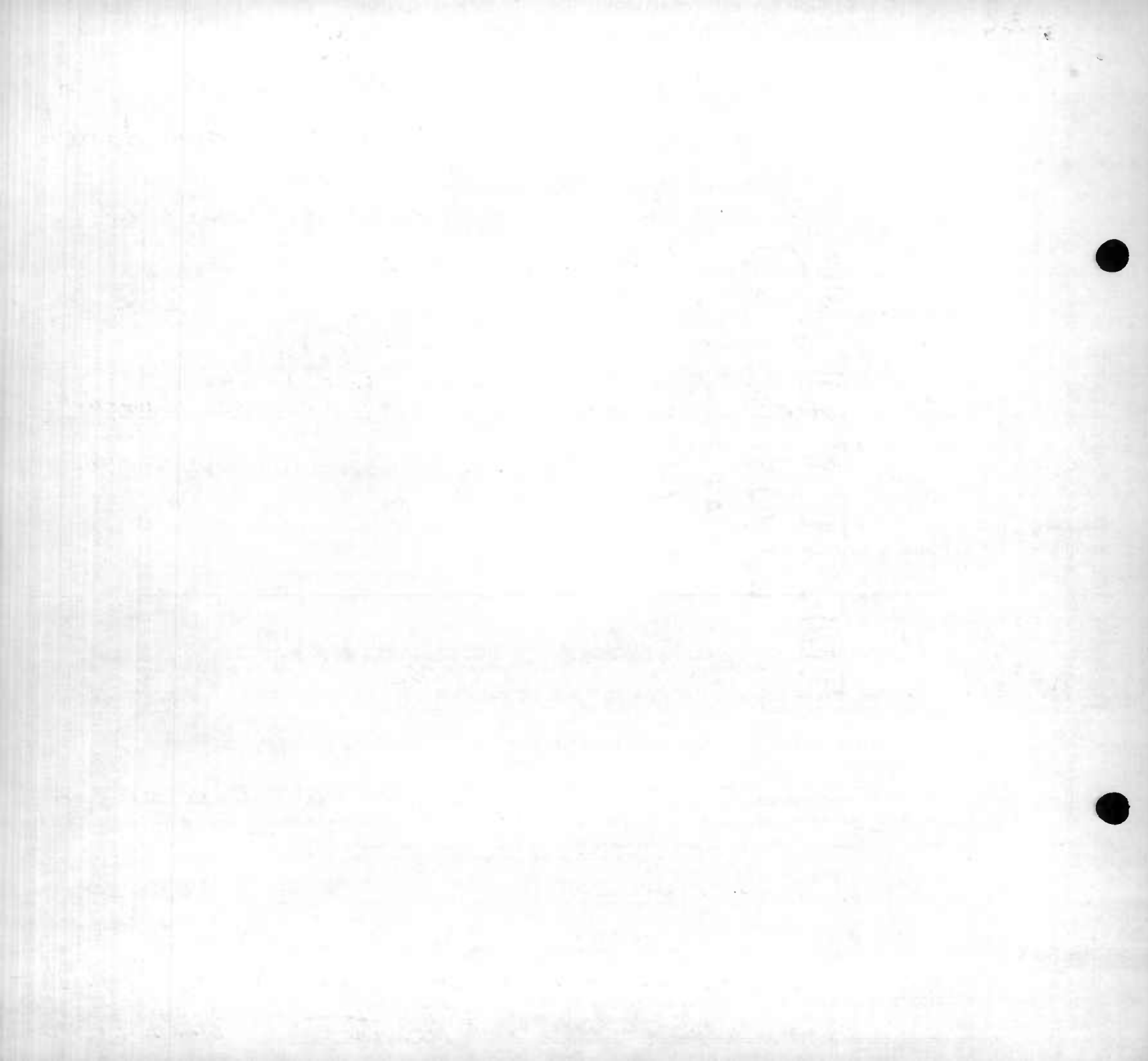
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

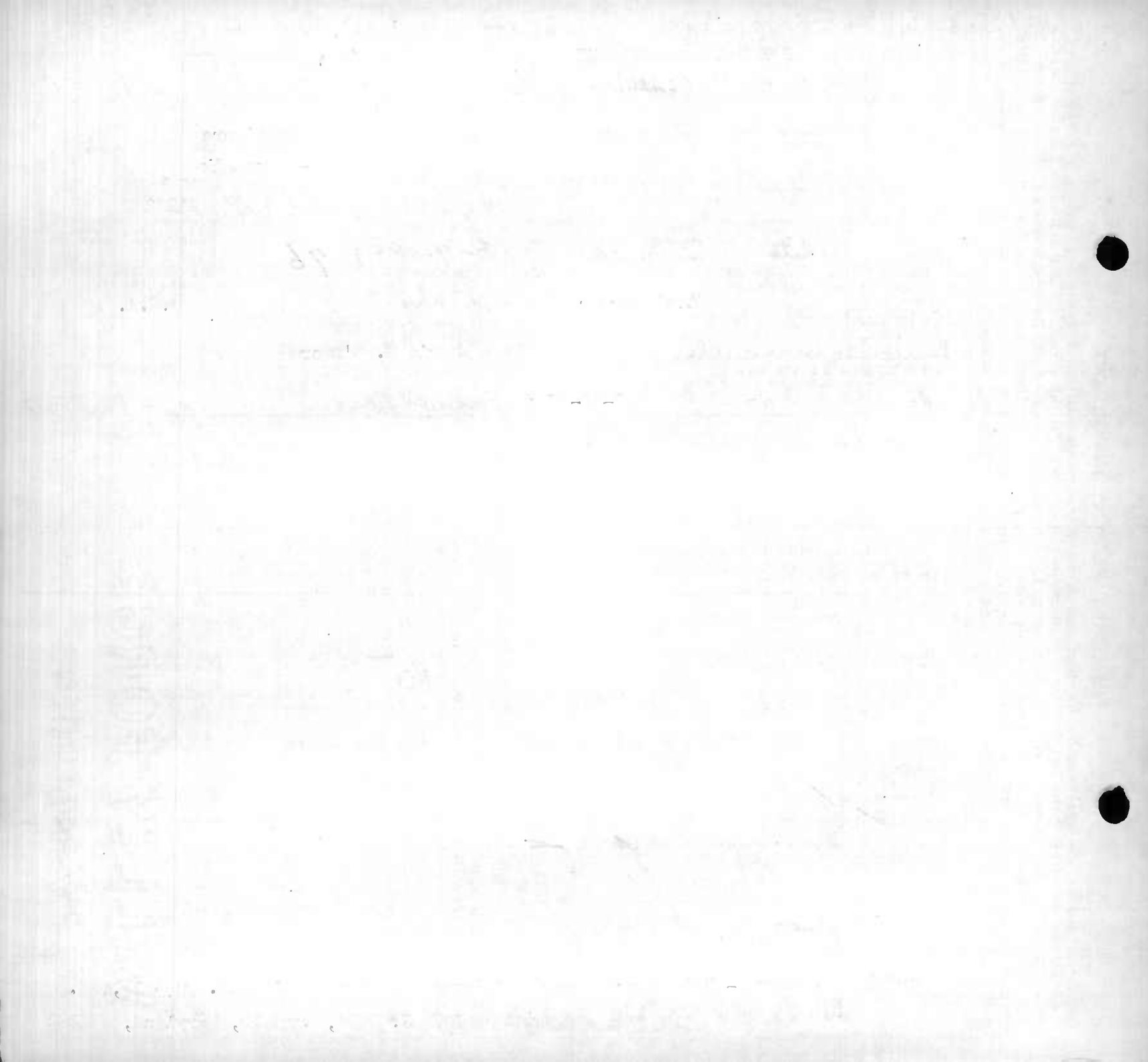
BALTIMORE CITY HEALTH DEPARTMENT										
66 06543					CERTIFICATE OF DEATH		Registered No. 66 06543			
BIRTH NO. 66 06543					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) SNYDER, ANNA					2. DATE AND HOUR OF DEATH JUNE 28, 1966 2 A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital					A. STATE Maryland B. COUNTY Anne Arundel					
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pasadena 52-00					
D. STREET ADDRESS (If rural, give location) Box 418 W. Shore Road										
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 7/26/91	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Bucha ? (Unknown)					14. MOTHER'S MAIDEN NAME (Unknown)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mr. John K. Gore (son-in-law)		ADDRESS Same As #2			
18. 334X I			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) Cerebral arterio sclerosis 2 wks							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) _____							
			(C) _____							
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from June 20 19 66 to June 28 19 66 , that (I) (we) last saw the deceased alive on June 27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Barry N. Rosenbaum M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/28/66		
23C. PHYSICIAN'S NAME (Type) BARRY N. ROSENBAUM M.D.						23D. ADDRESS University Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE July 2, 1966		24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966			25B. NAME OF REGISTRAR R. E. E. E.			25C. FUNERAL DIRECTOR R. V. Singleton			ADDRESS Singleton Funeral Home Glen Burnie, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

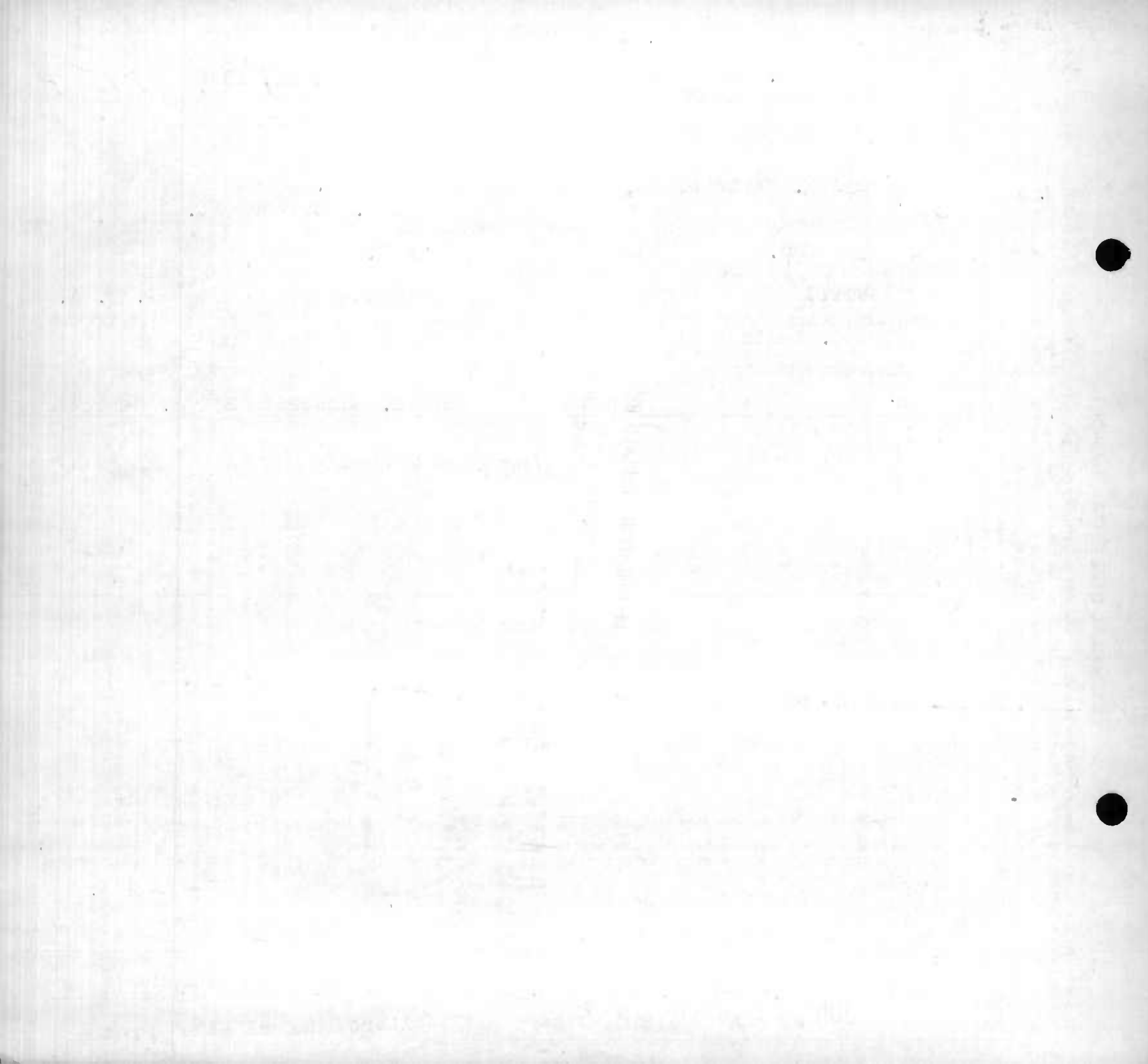
BIRTH NO. 66 06544		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06544	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) PASQUALE MACCALLINI				2. DATE AND HOUR OF DEATH 6-28-66 1:05 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore - 53-00 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - Dundalk D. STREET ADDRESS (If rural, give location) 2622 Ambler Rd. 21222			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 8-7-1889	9. AGE (In years lost birthday) 76	10. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY Steel Worker		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benedito MacCallini				14. MOTHER'S MAIDEN NAME Maria G. D'Amore			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 283-10-5588		17. INFORMANT Benny J. MacCallini			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH (A) <u>Cerebrovascular Accident 24 hrs.</u> (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-19-1966 to 6-28-1966, that (I) (we) last saw the deceased alive on 6-28-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Ramon U. Scharfz				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-28-66	
23C. PHYSICIAN'S NAME (Type) RAMON U. SCHARFZ				23D. ADDRESS Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 2-1966		24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Jesus		24D. LOCATION (City, town, or county) (State) German Hill Rd. Dundalk, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR JOHN J. DUDA, Dundalk, Maryland, 21222			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) A fracture of any kind; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06545		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06545	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Grace M. Sunstrom		2. DATE AND HOUR OF DEATH June 26, 1966 1:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 231 S. Stricker St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 19-03 D. STREET ADDRESS (If rural, give location) 231 S. Stricker St.			
5. SEX F	6. RACE Cau.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 7, 08	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Ira C. Zentz		14. MOTHER'S MAIDEN NAME Rhoda Wilhide	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. BY None		17. INFORMANT ADDRESS Earl E. Sunstrom 231 S. Stricker St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH sudden		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 26, 1966 to June 26, 1966, that (I) (we) last saw the deceased alive on June 26, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Morris B. Schreiber		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-27-66	
23C. PHYSICIAN'S NAME (Type) MORRIS B. SCHREIBER		23D. ADDRESS M.D. 1519 W. LOMBARD ST.			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-66		24C. NAME OF CEMETERY or CREMATORY Loudon Nat. Cemetery	
24D. LOCATION Baltimore Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Walters Funeral Home Pratt & Stricker Sts.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06546		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06546	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) John Riconikis		2. DATE AND HOUR OF DEATH June 25, 1966		1:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midtown Convalescent Home 90		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 14-01 D. STREET ADDRESS (If rural, give location) 1803 Eutaw Place			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 6-24-1880	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lithuania	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Downs 808 St. Paul St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, which rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture of Hip (R) Pinned		CAUSE OF DEATH (A) Cardio Respiratory Failure (B) Congestive Heart Failure (C) Gen Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 5-14-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Boarding Home 1803 Eutaw Pl		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 5-14-66		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell from chair	
22. I certify that (I) (this hospital) attended the deceased from June 2 1966 to June 25 1966, that (I) (we) last saw the deceased alive on June 25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Leonard J. Ruck, Inc.		23B. DATE SIGNED 6/25/66		23C. PHYSICIAN'S NAME (Type) William Appleford	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-66		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cem.	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. ADDRESS (State) 5305 Harford Rd		25A. DATE RECEIVED JUN 29 1966	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		25D. ADDRESS	

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Handwritten text, possibly a signature or name, appearing upside down.

Handwritten text, possibly a signature or name, appearing upside down.

FUNERAL DIRECTOR: IMPORTANT

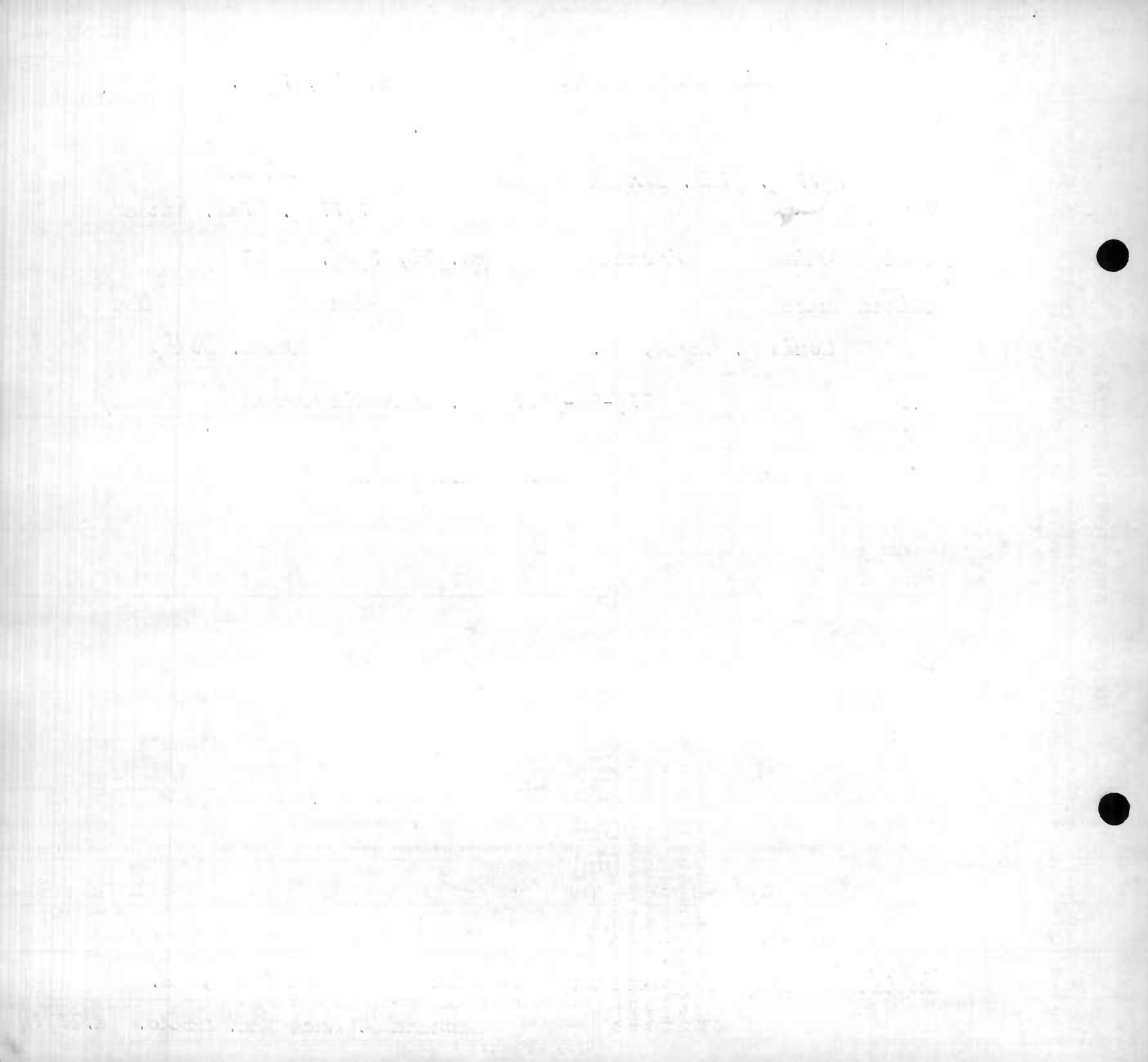
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06547	
BIRTH NO. 66 06547		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANTONIO LOVERDE (Antonio Loverde)		2. DATE AND HOUR OF DEATH 6/27/66 3:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 44		A. STATE MARYLAND B. COUNTY BALTIMORE			
If not in hospital or institution, give street address or location		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #6 2701			
		D. STREET ADDRESS (If rural, give location) 4100 MARK QUEENIE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/24/90	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pipe Fitter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Antonio Norman Loverde		14. MOTHER'S MAIDEN NAME Antoinette Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 220-03-4590		17. INFORMANT Mrs. Julia Loverde	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Myocardial Infarction DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/27/66 19 to 6/27/66 19, that (I) (we) last saw the deceased alive on 6/27/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. T. Boone M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6/27/66	
23C. PHYSICIAN'S NAME (Type) W. T. BOONE		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/66		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 06548	
BIRTH NO. 66 06548		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Edris Dolby Ortman</i>						2. DATE AND HOUR OF DEATH <i>June 27, 1966.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1911 E. 31st. Street</i>						A. STATE <i>Md.</i> B. COUNTY					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 9-06</i>					
						D. STREET ADDRESS (If rural, give location) <i>1911 E. 31st. Street</i>					
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Divorced</i>		8. DATE OF BIRTH <i>Apr. 21, 1904.</i>		9. AGE (In years last birthday) <i>62</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Nurse</i>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Louis E. Hayes, Sr.</i>						14. MOTHER'S MAIDEN NAME <i>Anna L. Dolby</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>219-20-5281</i>		17. INFORMANT <i>Mrs. Lucretia Kramer</i>				ADDRESS (Same)	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) <i>Coronary Thrombosis</i> DUE TO (B) <i>H A D H D</i> DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>5 years</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6/15/66</i> to <i>6/27</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>6/26/66</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>I. S. Zinberg</i>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>6/27/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>I. S. ZINBERG</i>						23D. ADDRESS <i>4000 W Northern Parkway (15)</i>					
24A. BURIAL CREMATION <i>Burial</i>		24B. DATE <i>6/29/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Greenmount Mausoleum</i>				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>6/29/66</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>				25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md.</i>			
				ADDRESS <i>21214</i>							



66 06549

BALTIMORE CITY HEALTH DEPARTMENT

66 06549

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)C.
MAURICE MASSEY

2. DATE AND HOUR PRONOUNCED DEAD

June 27, 1966

9:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

5517 Todd Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5517 Todd Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3/18/1903

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

B & O Railroad

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James C. Massey

14. MOTHER'S MAIDEN NAME

Molly Passmore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

705056065

17. INFORMANT

May A. Massey,

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

5517 Todd Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 27 66 9:25

21E. INJURY OCCURRED

P WHILE AT
m WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot self in head

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-28-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/1/66

23C. NAME OF CEMETERY or CREMATORY

Baltimore, Cemetery

23D. LOCATION

(City, town, or county)

(State)

Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 29 1966

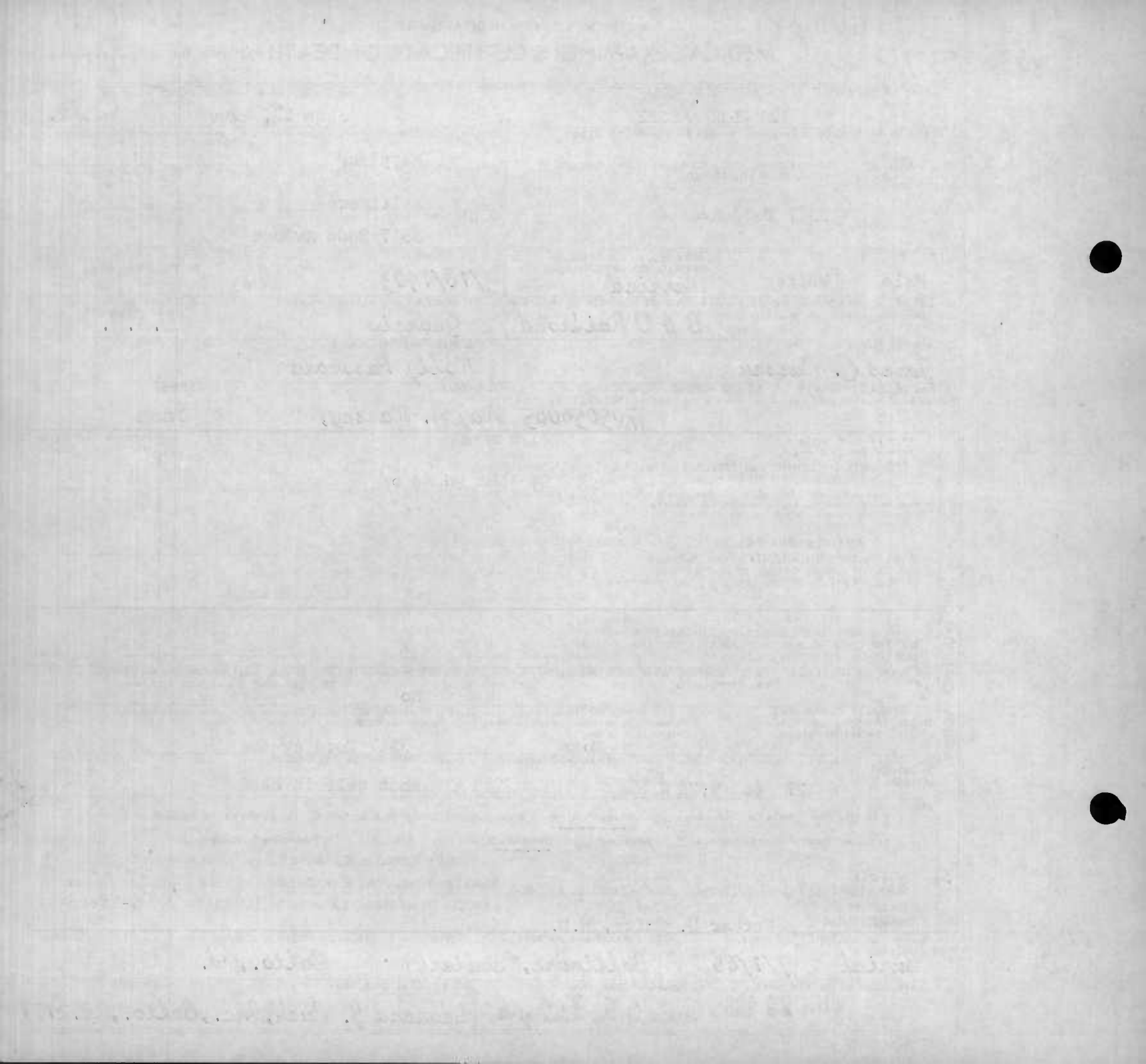
24B. NAME OF REGISTRAR

Robert E. Fink

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc., Balto., Md. 21214

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06550		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06550	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Katharina Noll		2. DATE AND HOUR OF DEATH June 27, 1966. 5:46 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 3701 Mary Avenue			A. STATE Md. B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-44		
D. STREET ADDRESS (If rural, give location) 3701 Mary Avenue					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Aug. 14, 1881	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Romania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Peter Kief Kiefer		14. MOTHER'S MAIDEN NAME Eva Holcxy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-7905D		17. INFORMANT Mr. Anton J. Noll	
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) cardio-renal vascular disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4-5 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. senility, heart generalized arterio-sclerosis.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 30 1966 to June 27 1966 , that (I) (we) last saw the deceased alive on June 26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. C. Tolsted				23B. DATE SIGNED June 28, 1966	
23C. PHYSICIAN'S NAME (Type) L. C. Tolsted				23D. ADDRESS 447 N. Kenwood Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/66		24C. NAME OF CEMETERY or CREMATORY Moreland Mem. Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	

June 2nd

June 1st

June 3rd

June 4th

June 5th

June 6th

June 7th

June 8th

June 9th

June 10th

June 11th

June 12th

June 13th

June 14th

June 15th

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06551		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06551	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Peter W. Bartel, Sr.			2. DATE AND HOUR OF DEATH 6-26-66 4 45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 2827 Lake Avenue FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
5. SEX M			6. RACE White		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married			8. DATE OF BIRTH Nov. 11, 1896		
9. AGE (in years last birthday) 69			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gasoline Business		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Peter D. Bartel			14. MOTHER'S MAIDEN NAME Mary A. Deer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215-03-8333		
17. INFORMANT Margaret J. Bartel, Sr.			ADDRESS Same		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Aortic Corony Occlusion INTERVAL BETWEEN ONSET AND DEATH Instant					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 15 1940 to June 28 1966. that (I) (we) last saw the deceased alive on 6-10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William L. Fearing				23B. DATE SIGNED 6-28-66	
23C. PHYSICIAN'S NAME (Type) William L. Fearing				23D. ADDRESS M.D. 3025 Belair Rd, Balt 13 Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE JUN 29 1966		24C. NAME of CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore, Md.		24E. STATE (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Fearing		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC. BALTIMORE, MD. "L" "L"	

West County, California

40 pages 2-10

X

2022 March 11, 1922

William L. Henry

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06552</u>	
BIRTH NO. <u>66 06552</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<u>George Joseph Borgmeier</u>		<u>June 28, 1966.</u> <u>4 A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <u>Md.</u> B. COUNTY	
<u>00</u>		<u>4121 Eierman Avenue</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>27-01</u>	
		D. STREET ADDRESS (If rural, give location)		<u>4121 Eierman Ave.</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>July 22, 1892</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Joseph F. Borgmeier</u>			14. MOTHER'S MAIDEN NAME <u>Ann B. Bauer</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-05-0420</u>		17. INFORMANT <u>Mrs. Helen Borgmeier</u>	
				ADDRESS <u>(Same)</u>	
18. <u>35-2X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Acute Coronic Arteriosclerosis</u> (B) DUE TO <u>Spastic Paraplegia</u> (C)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Hour</u> <u>25 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 15</u> 19 <u>38</u> to <u>June 28</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>June 27</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William L. Fearing</u>				23B. DATE SIGNED <u>6-28-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>William L. Fearing</u>				23D. ADDRESS <u>3025 Belair Rd, Balt-13 Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fearing, MA</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>	
				ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06553		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06553	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CASSIE BELL YOUNG			2. DATE AND HOUR OF DEATH June 28, 1966 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 So. Balto. Gen. Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3702 Leo St.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Marries	8. DATE OF BIRTH 7-11-1903	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: If Under 24 Hrs. Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William Triggs			14. MOTHER'S MAIDEN NAME Viola Bell Hughes		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-09-6362		17. INFORMANT ADDRESS Mr. Edward A. Young, 3702 Leo St. 21226
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11-260X CORONARY THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus			CAUSE OF DEATH (A) DUE TO Coronary Thrombosis (B) DUE TO Arteriosclerosis C.V. disease (C) DUE TO TE		INTERVAL BETWEEN ONSET AND DEATH 2 hours 5 years 11 years
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/28 1954 to 6/28 1966, that (I) (we) last saw the deceased alive on June 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sidney R. Gehlert			23B. DATE SIGNED 6/28/66		
23C. PHYSICIAN'S NAME (Type) Sidney R. Gehlert			23D. ADDRESS 4708 Pennungton Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-66		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION Baltimore		24E. LOCATION Baltimore		24F. LOCATION Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Flynn & Fleming, 1422 Light St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06554	
BIRTH NO. 66 06554		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 6-28-66 7 45 P.M.	
M.E. CASE NO.		NAME OF DECEASED Sigmund Mandel		PLACE OF DEATH IN BALTIMORE MARYLAND	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
CERTIFICATE AMENDED <small>FILE IN M. OF HOSPITAL OR INSTITUTION</small> <small>(If not a hospital or institution, give address or location)</small>		5. SEX MALE		6. RACE WHITE	
		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 11-13-93	
9. AGE (In years lost birthday) 72 1/2		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Mining	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Peru		13. FATHER'S NAME JACOB MANDEL	
14. MOTHER'S MAIDEN NAME Josephine Gluecksmann		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Julie Mandel		18. ADDRESS Same		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
20. CAUSE OF DEATH		21. INTERVAL BETWEEN ONSET AND DEATH		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		24. ANTECEDENT CAUSES		25. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
26. UREMIA		27. CHRONIC GLOMERULONEPHRITIS		28. CONGESTIVE HEART FAILURE	
29. MEDICAL CERTIFICATION		30. MEDICAL CERTIFICATION		31. MEDICAL CERTIFICATION	
32. MEDICAL CERTIFICATION		33. MEDICAL CERTIFICATION		34. MEDICAL CERTIFICATION	
35. MEDICAL CERTIFICATION		36. MEDICAL CERTIFICATION		37. MEDICAL CERTIFICATION	
38. MEDICAL CERTIFICATION		39. MEDICAL CERTIFICATION		40. MEDICAL CERTIFICATION	
41. MEDICAL CERTIFICATION		42. MEDICAL CERTIFICATION		43. MEDICAL CERTIFICATION	
44. MEDICAL CERTIFICATION		45. MEDICAL CERTIFICATION		46. MEDICAL CERTIFICATION	
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59. MEDICAL CERTIFICATION		60. MEDICAL CERTIFICATION		61. MEDICAL CERTIFICATION	
62. MEDICAL CERTIFICATION		63. MEDICAL CERTIFICATION		64. MEDICAL CERTIFICATION	
65. MEDICAL CERTIFICATION		66. MEDICAL CERTIFICATION		67. MEDICAL CERTIFICATION	
68. MEDICAL CERTIFICATION		69. MEDICAL CERTIFICATION		70. MEDICAL CERTIFICATION	
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92. MEDICAL CERTIFICATION		93. MEDICAL CERTIFICATION		94. MEDICAL CERTIFICATION	
95. MEDICAL CERTIFICATION		96. MEDICAL CERTIFICATION		97. MEDICAL CERTIFICATION	
98. MEDICAL CERTIFICATION		99. MEDICAL CERTIFICATION		100. MEDICAL CERTIFICATION	

VS 153--6/30/66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06555		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06555	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Michael Kaczmarczyk</i>		2. DATE AND HOUR OF DEATH <i>6-26-66 13:05 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2401</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	
8. DATE OF BIRTH <i>9/14/1892</i>		9. AGE (In years last birthday) <i>73</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Longshoreman</i>	
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>Poland</i>		13. FATHER'S NAME <i>Stanislaus Kaczmarczyk</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-01-1296</i>	
17. INFORMANT <i>Rozalia Kaczmarczyk</i>		18. ADDRESS <i>1332 Andre St.</i>			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Bronchogenic carcinoma</i>		20. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <i>Bronchopneumonia</i>		21. INTERVAL BETWEEN ONSET AND DEATH <i>2 YEARS</i> <i>48 HRS</i>	
22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>EMPHYSEMA</i> <i>CHRONIC BRONCHITIS</i>		23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>0</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>0</i> 20A. AUTOPSY? (Yes or No) <i>0</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>0</i>		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. HOW DID INJURY OCCUR? <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <i>June 6</i> 19 <i>66</i> to <i>June 26</i> 19 <i>66</i> . that (I) (we) last saw the deceased alive on <i>June 26</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E. S. Hoffman MD</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-26-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. S. Hoffman</i>		23D. ADDRESS M.D. <i>South Baltimore General Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/30/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Rosary Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. DATE REC'D BY HEALTH DEPT. <i>JUN 29 1966</i>		24F. NAME OF REGISTRAR <i>Charles L. Stevens</i>	
24G. FUNERAL DIRECTOR <i>Charles L. Stevens Funeral Home, Inc.</i>		24H. ADDRESS <i>1501 E. Fort Avenue</i>			

Medical Department

South Baltimore General Hospital

11-10-45

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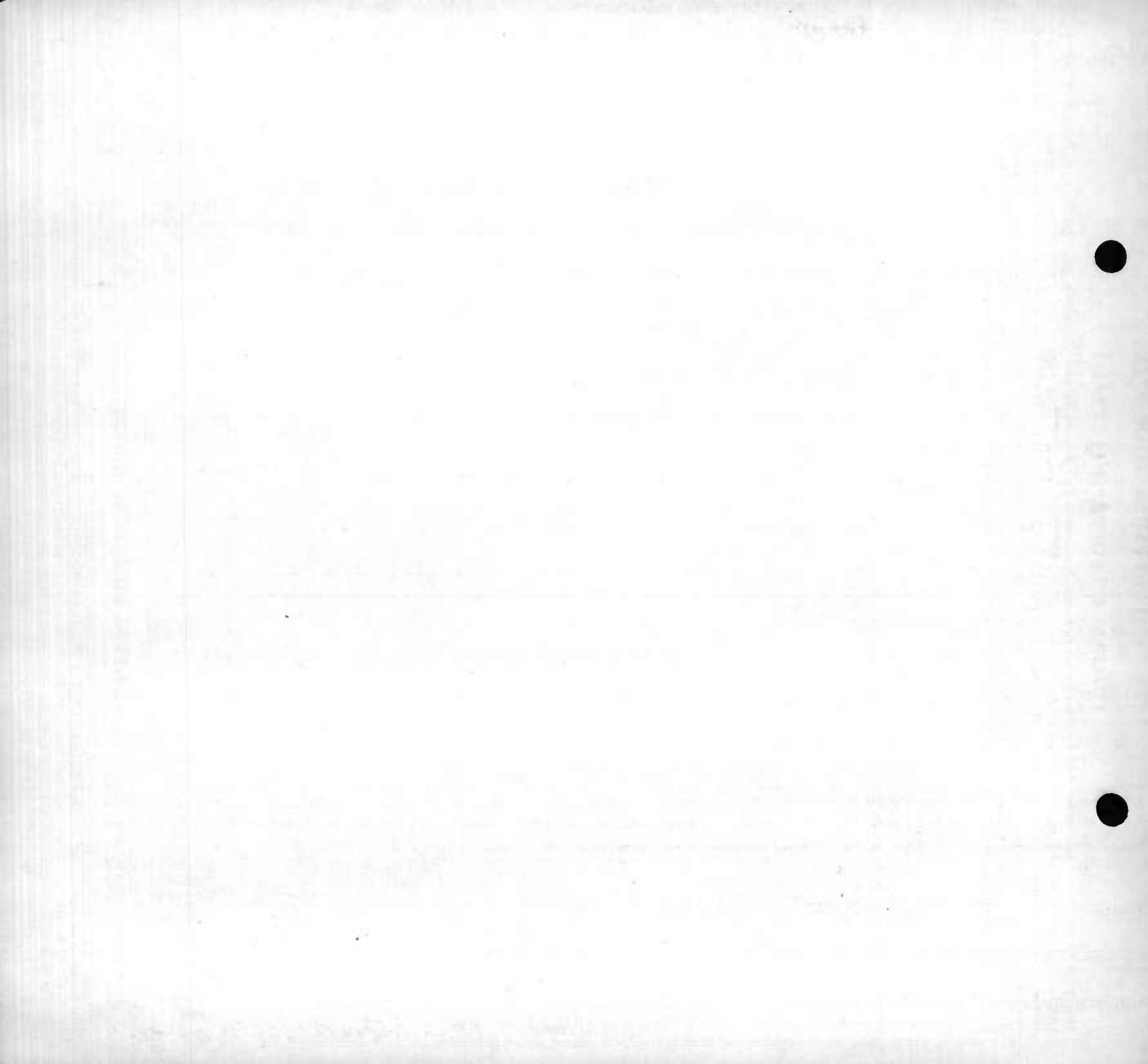
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06556		BALTIMORE CITY HEALTH DEPARTMENT 27-17-79 B GU	
M.E. CASE NO.		CERTIFICATE OF DEATH X Registered No. 66 06556	
1. NAME OF DECEASED (Type or Print) Paul Plemmons		2. DATE AND HOUR OF DEATH June 24, 1966 10 10 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		A. STATE Maryland B. COUNTY Balto	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00	
		D. STREET ADDRESS (If rural, give location) 247 St. Helena Ave.	
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/8/04
9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter	10B. KIND OF BUSINESS OR INDUSTRY STEEL	11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Larkin Plemmons		14. MOTHER'S MAIDEN NAME Jane Whitaker	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. -	17. INFORMANT Wife Clinical Record
ADDRESS Same			
18. I 181.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of Urinary Bladder DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 5-13-66	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Bladder	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-24 1966 to 6-24 1966, that (I) (we) last saw the deceased alive on 6-24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ralph M. Howard		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED June 24, 1966
23C. PHYSICIAN'S NAME (Type) Ralph M. Howard		23D. ADDRESS University Hospital Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6-28-66	24C. NAME OF CEMETERY or CREMATORY Mt. Zion Cemetery	24D. LOCATION (City, town, or county) (State) HARFORD COUNTY, MD.
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS ULRICH FUNERAL HOME, DOWNTOWN, MD.	



FUNERAL DIRECTOR: IMPORTANT

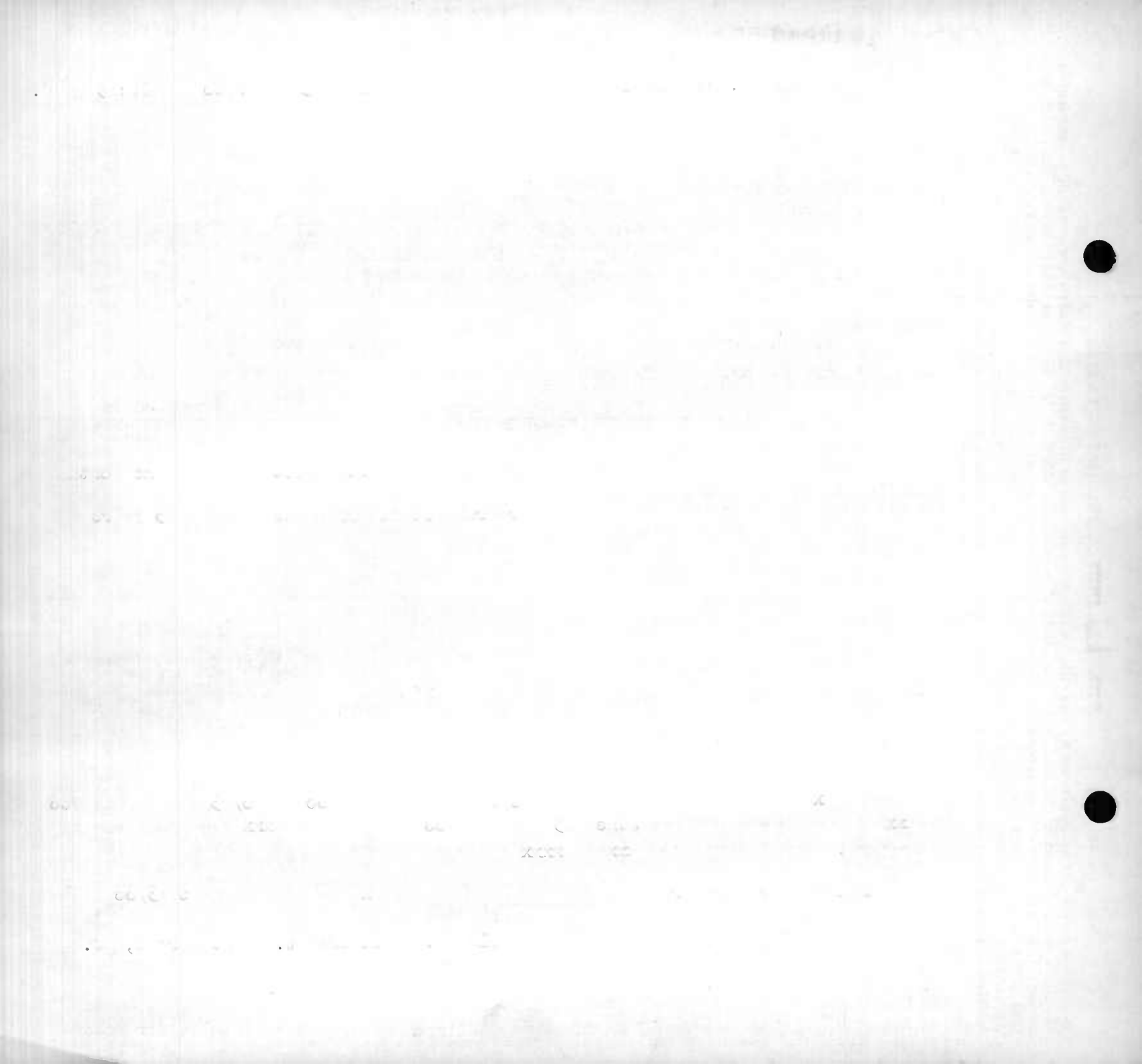
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>66 06557</u>	
BIRTH NO. <u>66 06557</u>		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Edward J. Strain</u>						2. DATE AND HOUR OF DEATH <u>6/27/66</u> <u>9</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> <u>2025 20. Fayette St</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Md.</u>		B. COUNTY <u>Balto</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u>			
34				D. STREET ADDRESS (If rural, give location) <u>3100 Sollers Point Rd</u> # <u>22</u>							
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>7/13/03</u>		9. AGE (In years lost birthday) <u>62</u>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Howard M. Strain</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth McDonnell</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>212-05-3846</u>		17. INFORMANT ADDRESS <u>MISS PEGGY STRAIN-3100 SOLLERS PT. RD</u>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I</u>				CAUSE OF DEATH (A) <u>Myocardial Infarction</u> (B) <u>Arteriosclerotic Heart Disease</u> (C) _____				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>II</u>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Bronchopneumonia</u>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>June 3</u> 19 <u>66</u> to <u>June 27</u> 19 <u>66</u> . that (I) (we) last saw the deceased alive on <u>June 27</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Josephine Brindley</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>June 27, 1966</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. K. E. Beling</u>						23D. ADDRESS <u>Bon Secours Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/30/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>LOURON PARK</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1966</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>ULLRICH FUNERAL HOME-47210 BELAIR</u>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06558</u>	
BIRTH NO. <u>66 06558</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Blanche E. Humphreys</u>		2. DATE AND HOUR OF DEATH <u>June 23 1966 10:45 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bolton Hill Con Home</u> <u>90 John & Lanvale Sts</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>2709</u> B. COUNTY			
5. SEX <u>Female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED <u>WIDOW</u> (specify)	8. DATE OF BIRTH <u>Nov 21 1881</u>	9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Charles Burgan</u>			
14. MOTHER'S MAIDEN NAME <u>Florence Getzdauer</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Harry W Humphreys 1513 Kingsway Rd</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cerebral Thrombosis, Left</u> DUE TO <u>Cerebral Arteriosclerosis</u> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>One Month</u> <u>5 Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6/8</u> 19 <u>66</u> to <u>6/23</u> 19 <u>66</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 23</u> 19 <u>66</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley Z. Felsenberg</u>				23B. DATE SIGNED <u>6/23/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Stanley Z Felsenberg M.D.</u>				23D. ADDRESS M.D. <u>1129 E. Baltimore St. Baltimore 2, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>June 27/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>	
24D. LOCATION <u>Baltimore</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Ullrich Funeral Home 4210 Belair Road</u>			



FUNERAL DIRECTOR: IMPORTANT

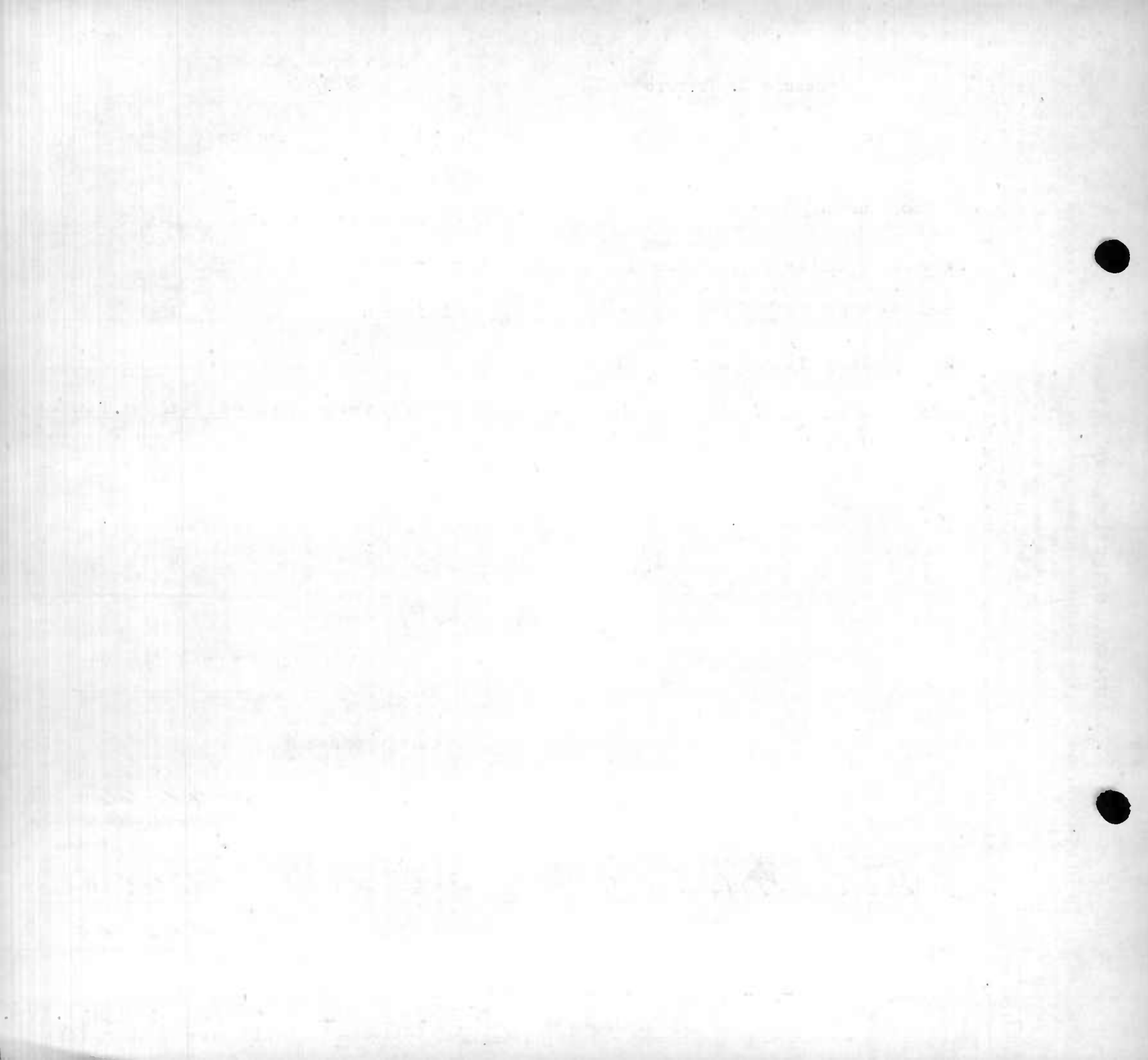
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06559		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06559	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		GOODE, CHETTIE-R		June 25, 1966 6⁰⁰ P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)		Maryland		19-03	
36 Franklin Square Hospital		Baltimore		23	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
female		white		SEP.	
8A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8B. DATE OF BIRTH		9. AGE (In years last birthday)	
Disabled		9-9-1905		60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Disabled		Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
GILES BOWDEN		BESSIE VAUGHT		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS		BESSIE WILLIAMS 734 Yale AVE	
18. 4-20-01		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO		ARTERIOSCLEROTIC HEART DISEASE	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO		12 YRS.	
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from June 25 1966 to June 25 1966, that (I) (we) lost saw the deceased alive on June 25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE	
Jong-Hi Bek		M.D.		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)	
JONG-HI BEK		Franklin Square Hospital Baltimore Md		24B. DATE	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION		25A. DATE REC'D BY HEALTH DEPT.	
Burial		June 28, 1966 Meadowridge Cemetery		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		ADDRESS		25D. NAME OF REGISTRAR	
G. Truman Schwab		3512 Frederick Ave. Balto.		25E. NAME OF REGISTRAR	
25F. NAME OF REGISTRAR		25G. NAME OF REGISTRAR		25H. NAME OF REGISTRAR	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06560</u>	
BIRTH NO. <u>66 06560</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH <u>6/28/66</u> M.		
1. NAME OF DECEASED (Type or Print) <u>Bessie N. Travers</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Hood Nursing Home</u>			A. STATE <u>Maryland</u> B. COUNTY <u>Balto</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
			D. STREET ADDRESS (If rural, give location) <u>29th Street 5313 Edmondson AVE</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>10-16-1877</u>	9. AGE (In years last birthday) <u>88</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleswoman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sales</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Henry Clay Travers</u>			14. MOTHER'S MAIDEN NAME <u>Wall</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Ollie Travers 516 Wilton Rd. Towson 4</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>1. 15-2X I</u> <u>P.A. of Paucerean</u> <u>3 mon</u>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>a.s.c.v.d</u>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <u>0 0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>6-1-58</u> 19 to <u>6-28-66</u> 19 that (I) (we) lost saw the deceased alive on <u>6-27-66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James H. Howell</u>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6-28-66</u>
23C. PHYSICIAN'S NAME (Type) <u>James H. Howell</u>			23D. ADDRESS M.D. <u>1011 Frederick Rd. 28</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6-30-66</u>	24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
25A. DATE RECEIVED BY HEALTH DEPT. <u>JUN 29 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR ADDRESS <u>4600 Liberty Hgts. Ave. Baltimore 7 Maryland</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06561		Registered No. 66 06561	
CERTIFICATE OF DEATH 1. NAME OF DECEASED (Type or Print) <i>(WARREN)</i> JAMES FREEMAN				2. DATE AND HOUR OF DEATH 6/28/66 4:45p M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 8-03 D. STREET ADDRESS (If rural, give location) 2733 E. BIDDLE STREET			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-26-90	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Steelworker</i>			11. BIRTHPLACE (State or foreign country) <i>Colquhoun S. C.</i>		12. CITIZEN OF WHAT COUNTRY? _____		
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS <i>Aphelia Freeman 2733 E Biddle</i>		
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia- ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO _____ (B) DUE TO _____ (C) DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH about 1 week	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____			
22. I certify that <u>(I) (this hospital)</u> attended the deceased from 6/24/66 19 to 6/28/66 19, that <u>(I) (myself)</u> last saw the deceased alive on 6/28/66 19 and that in <u>(my) (myself)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I) (myself)</u> (did) (did not) view the body after death.							
23A. SIGNATURE <i>Daniel G. Robinhold</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/28/66	
23C. PHYSICIAN'S NAME (Type) Daniel G Robinhold				23D. ADDRESS JHH			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 2/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Mem. Park - Arbutus, Md</i>		24D. LOCATION (City, town, or county) (State) _____	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Zora F. Elickson 11297 Canton St</i>			

1875

Alfred S. C.

Alfred S. C.

Alfred S. C.

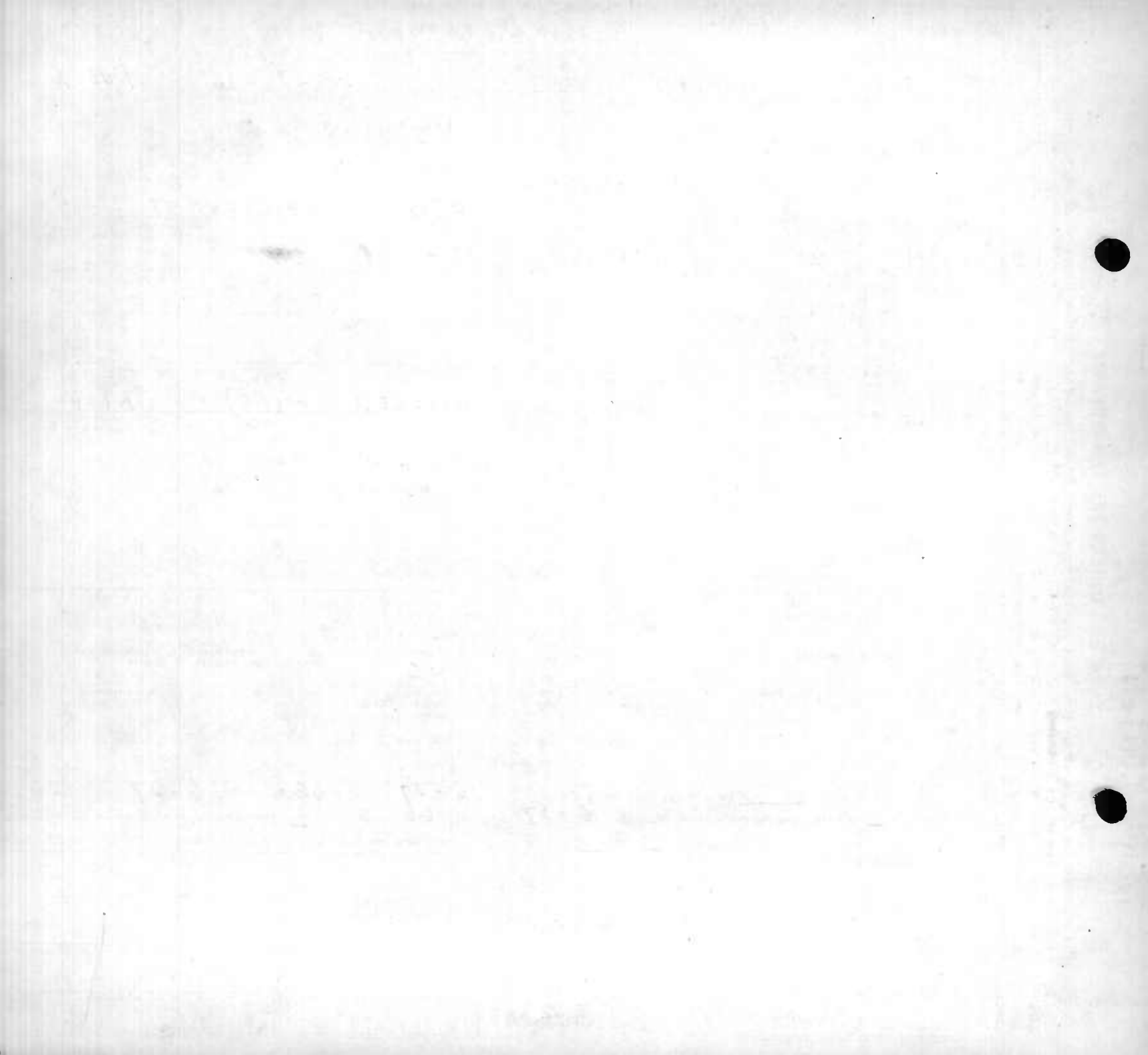
Alfred S. C.

Alfred S. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06562				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06562	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				(Type or Print) TALLEY, CHARLES		6-27-66 9:40 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE MARYLAND			
LUTHERAN HOSP. OF MARYLAND				B. COUNTY BALTIMORE			
5. SEX M				6. RACE C		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 10-9-06				9. AGE (In years, months, days) 59		10. IF UNDER 1 Yr. Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Middleburg, N.C.	
13. FATHER'S NAME Alfred Talley				14. MOTHER'S MAIDEN NAME Ella Talley		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-09-8553H		17. INFORMANT MILDRED (WIFE)	
18. 420.1 I				CAUSE OF DEATH		ADDRESS SAME	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO 4 PULMONARY EDEMA			
ANTECEDENT CAUSES				(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				① Hypertensive Arteriosclerosis ② Chronic Pyelonephritis ③ Diabetes Mellitus			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-27 1966 to 6-27 1966 , that (I) (we) last saw the deceased alive on 6-27 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Desideria T. Mahusay		23B. DATE SIGNED 6-27-66	
23C. PHYSICIAN'S NAME (Type) DESIDERIA T. MAHUSAY				23D. ADDRESS M.D. LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-66		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Mortone Dyett F.H.		ADDRESS 1701 Laurens St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06563		CERTIFICATE OF DEATH		Registered No. 66 06563	
1. NAME OF DECEASED (Type or Print) Lelia I. Graves						2. DATE AND HOUR OF DEATH June 28, 1966 7⁴⁵ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3214 W. Belvedere Ave.						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-18 D. STREET ADDRESS (If rural, give location) 3214 W. Belvedere Ave.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1/4/1875	9. AGE (In years last birthday) 91	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Price			14. MOTHER'S MAIDEN NAME R. Mather						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Frances S. Hipp (Same)				
18. 42011 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Coronary Sclerotic Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis (generalized)						CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II						INTERVAL BETWEEN ONSET AND DEATH 12 years 20 years			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from December 16 19 46 to June 28 19 66 , that (I) (we) last saw the deceased alive on January 6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE W. Grafton Hersberger M.D.						23B. DATE SIGNED 6-29-66			
23C. PHYSICIAN'S NAME (Type) W. Grafton Hersberger M.D.						23D. ADDRESS Medical Arts Building			
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		24B. DATE 6/30/1966		24C. NAME OF CEMETERY or CREMATORY Spring Hill		24D. LOCATION (City, town, or county) (State) Huntington, W. Va.			
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.					

Trattato di pace
(1763)

Robert Johnson

James Johnson

10. 2. 1763

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 06564					CERTIFICATE OF DEATH			Registered No. 66 06564	
1. NAME OF DECEASED (Type or Print) <u>Charlotte Katherine Mueller Yoash</u>					2. DATE AND HOUR OF DEATH <u>June 27, 1966 11:30 A.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Harford Gardens Nursing Home</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>9-01</u> D. STREET ADDRESS (If rural, give location) <u>3734 Ellerslie Ave.</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u>		8. DATE OF BIRTH <u>Oct. 12, 1898</u>	9. AGE (In years lost birthday) <u>67</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Louis A. Mueller</u>			14. MOTHER'S MAIDEN NAME <u>Eleanor Frak</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Paul J. Yoash</u> (Same)		ADDRESS		
18. <u>199.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Generalized Carcinomatosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Primary site undetermined</u>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u>		
MEDICAL CERTIFICATION									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased, from <u>June 11</u> 19 <u>66</u> to <u>June 27</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>June 26</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE <u>Loy M. Zimmerman</u> M.D., Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <u>6/27/66</u>				
23C. PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman</u>					23D. ADDRESS <u>3202 Harford Road</u>				
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/28/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkas</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Rd. Baltimore, 12, Md.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06565		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06565	
M.E. CASE NO.		CERTIFICATE OF DEATH		June 27, 1966	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		10 ⁴⁵ A M.	
Ralph O. Bordley		June 27, 1966		10 ⁴⁵ A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalescent Home		Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 2303 Pentland Drive		27-01	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5/2/1891	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sup't.		10B. KIND OF BUSINESS OR INDUSTRY Terminal Warehouse		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Harry F. Bordley		14. MOTHER'S MAIDEN NAME Mary Thompson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-5554		17. INFORMANT Corinne C. Bordley (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Acute Corning occlusion</i> DUE TO (B) <i>Diabetes Mellitus</i> DUE TO (C) <i>Hypertensive Cardiomyopathy/H.D.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>18 Hours</i> <i>year</i> <i>year</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 15</i> 19 <i>38</i> to <i>6-27</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>6-27</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William L. Fearing</i>				23B. DATE SIGNED <i>6-28-66</i>	
23C. PHYSICIAN'S NAME (Type) William L. Fearing				23D. ADDRESS 3025 Belair Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/1966		24C. NAME of CEMETERY or CREMATORY Springfield	
24D. LOCATION Sykesville, Md.		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Fearing</i>		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Baltimore, 12, Md.	

Chas. Henry Adams

London, England

My dear Sir,

1862

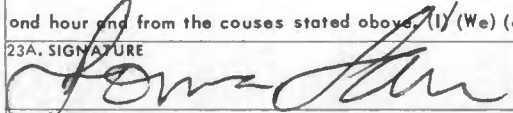
1862

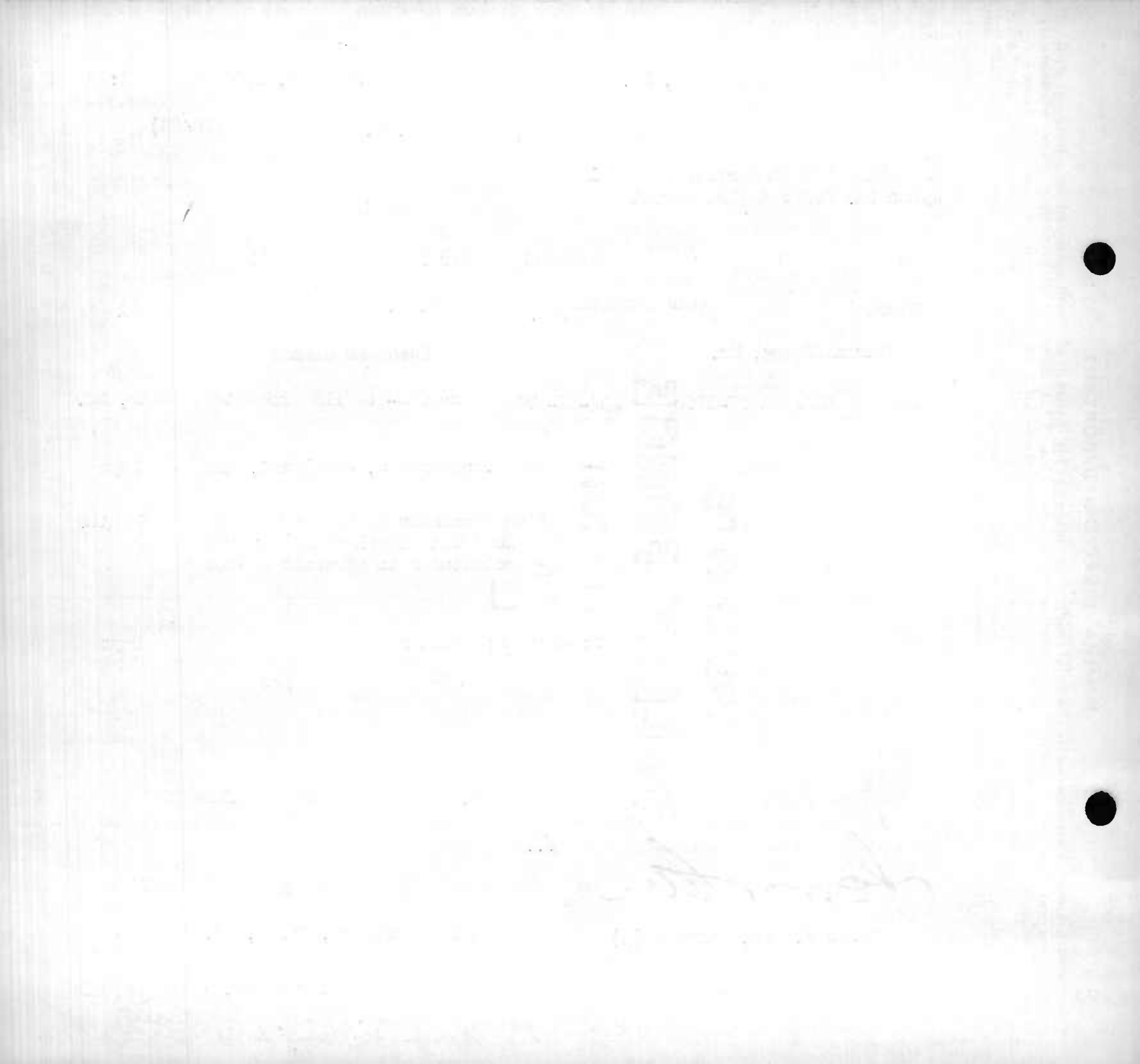
X

William L. G. Smith

FUNERAL DIRECTOR: IMPORTANT

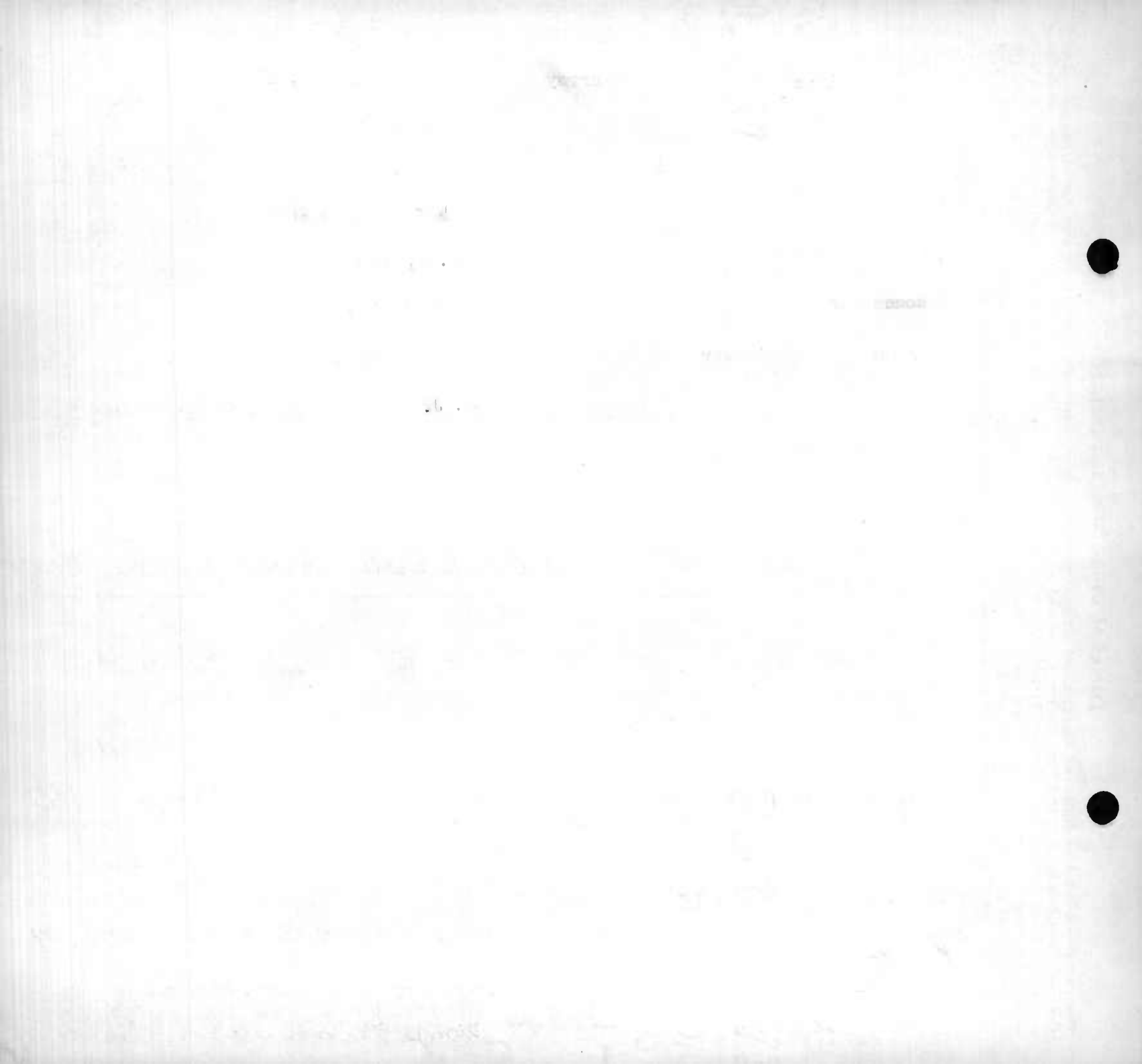
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 06566					CERTIFICATE OF DEATH					Registered No. 66 06566				
1. NAME OF DECEASED (Type or Print) Samuel Bragg, Jr.					2. DATE AND HOUR OF DEATH June 28, 1966 1:15 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE W.Va. B. COUNTY (26408) V-45					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Mount Clare				
					D. STREET ADDRESS (If rural, give location) Box 47									
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 8/3/32		9. AGE (In years last birthday) 33		10. If Under 1 Yr. Months: Days: Hours: Min.		11. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard					10B. KIND OF BUSINESS OR INDUSTRY Vets Hospital W.Va.					11. BIRTHPLACE (State or foreign country) W.Va.				
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME Samuel Bragg, Sr.					14. MOTHER'S MAIDEN NAME Hazel Mc Ginnis				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USAF 1952-1956					16. SOCIAL SECURITY NO. 234-52-7529					17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										INTERVAL BETWEEN ONSET AND DEATH Days Months				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Esophagitis; colitis										Days				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) yes				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from Apr. 26 1966 to June 28 1966, that (I) (we) last saw the deceased alive on June 28 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE 					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 6/28/66				
23C. PHYSICIAN'S NAME (Type) Thomas J. Lau, Surgeon (R)					23D. ADDRESS M.D. US PHS Hospital, Balto, Md.									
24A. BURIAL CREMATION, REMOVAL (Specify) Removal					24B. DATE 6/29/1966					24C. NAME of CEMETERY or CREMATORY Clarksburg, West Virginia				
24D. LOCATION (City, town, or county) (State)					25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966					25B. NAME OF REGISTRAR Robert E. Fairburn				
25C. FUNERAL DIRECTOR ADDRESS Wm. J. Tibner & Son Balto, Md.					25D. FUNERAL DIRECTOR Wm. J. Tibner & Son Balto, Md.									



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06567	
BIRTH NO. 66 06567		CERTIFICATE OF DEATH	
M.E. CASE NO.		M.	
1. NAME OF DECEASED (Type or Print) Minna Murray		2. DATE AND HOUR OF DEATH June 25, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Agnes Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 400 Edesdale Road		29	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Oct. 1, 1887
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 78
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Dittmar		14. MOTHER'S MAIDEN NAME Barbara	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. J. Edward Graff		ADDRESS 1339 Howard Road	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Cardio-Respiratory failure (B) DUE TO Acute Coronary Thrombosis (C) Arteriosclerotic Cardio Vascular Disease	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 1966 to 25 June 1966 , that (I) (we) last saw the deceased alive on 25 June 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William J. Bryson		23B. DATE SIGNED 28 June 66	
23C. PHYSICIAN'S NAME (Type) William J. Bryson		23D. ADDRESS 4605 Edmondson Ave Balto. 29	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/1966	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Wm. J. Fickner & Sons		ADDRESS Baltimore, Md.	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 06568

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BERTHA MICHAEL

2. DATE AND HOUR PRONOUNCED DEAD

June 27/66 4:20 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

36 FRANKLIN SQUARE NO 3A

4. USUAL RESIDENCE Where deceased lived. (If institution: residence before admission)

A. STATE Maryland B. COUNTY A

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

GLEN BURNIE 52-00

D. STREET ADDRESS (If rural, give location)

204 OAK LANE

5. SEX

Fem

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

12/10/1900

9. AGE (In years last birthday)

65

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Wrapper

10B. KIND OF BUSINESS OR INDUSTRY

Bookbinding

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William V. Michael

14. MOTHER'S MAIDEN NAME

Margaret A. Marburger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

213-09-9470

17. INFORMANT

Mrs. Mildred Klingenberg same address

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Subarachnoid and Subdural Hemorrhage originating from ruptured aneurysm of Circle of Willis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Dr. Werner U. Spitz

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6.28.66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

7/1/1966

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

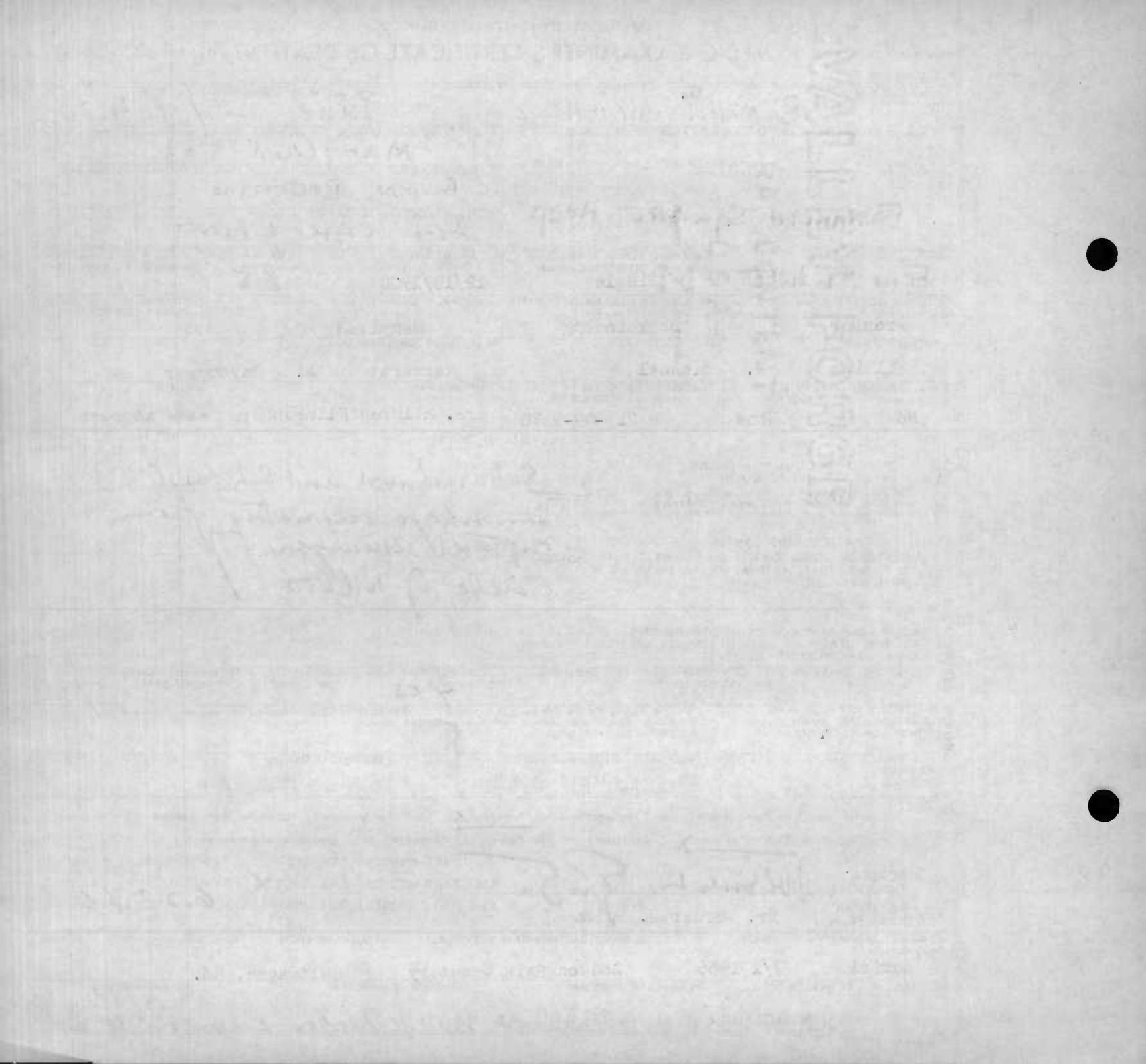
24C. FUNERAL DIRECTOR

ADDRESS

JUN 29 1966

R. E. E. Farley, M.D.

Wm. J. Tichner, Sons north L.P.A. Balto., Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06569		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06569	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HECK, EMMA Anna				2. DATE AND HOUR OF DEATH June 28 '66 8:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		CITY OR TOWN (If outside city limits, write RURAL and give township)		A. STATE MD		B. COUNTY Baltimore Balto	
Union Memorial Hospital		Lutherville Maryland 53-00		D. STREET ADDRESS (If rural, give location)		College Manor Nursing Home	
44		Semiary Avenue					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 01-25-73	9. AGE (In years last birthday) 93	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME J. FREDRICK HECK				14. MOTHER'S MAIDEN NAME LOUISE, RIPPAMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. William B. McCloskey 6306 Mossway			
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Cerebral Hemorrhage = terminal Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 days			
ANTECEDENT CAUSES		(A) DUE TO		(B) DUE TO Hypertensive arteriosclerosis Years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 24 1966 to June 28 1966, that (I) (we) last saw the deceased alive on June 28 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE WEN HAN TSUNG M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) WEN-HAN TSUNG M.D.				23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/1966		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Wm. J. Fisher & Sons		ADDRESS Balto. Md.	

RECEIVED
JUN 28 1966

WEN-HYI TSE
JUN 28 1966

X

Hypertensive arteriosclerosis

Cerebral Hemorrhage =
terminal thrombosis

LOUISE, KATHARINE

MARYLAND

HECK

FREDRICK

single

Female, white

01-25-73

2000-10-10

General Hospital

MD

Pathologist

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06570		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06570	
M.E. CASE NO.		CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) MAMIE GIBBS	
2. DATE AND HOUR OF DEATH		6/25/66		10:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE MARYLAND B. COUNTY Prince Georges	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
Lincoln Nursing Home		FARMOUNT HEIGHTS 66-00		700 61st AVENUE	
5. SEX F	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH MARCH 16, 1906	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Summie Butner		14. MOTHER'S MAIDEN NAME Georgiana Butner		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS Maudie Diggs Same as 4D	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CVA, Multiple Decubiti					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/20/66 19 to 6/25/66 19 that (I) (we) last saw the deceased alive on 6/25/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harris Tennarine, M.D.		23B. DATE SIGNED 6/25/66			
23C. PHYSICIAN'S NAME (Type) HARRIS TENNARINE		23D. ADDRESS 5519 KENNISON AVENUE, BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-29-66		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cem.	
24D. LOCATION (City, town, or county) Washington D.C.		24E. DATE REC'D BY HEALTH DEPT. JUN 29 1966		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR H.S. W. Workington & S.		24H. ADDRESS 4925 Dean Ave. N.E.D.C.			

Gov. Joseph Smith

10/22/92

Reuben

James M. Smith

2/20/22

2000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 06571				CITY HEALTH DEPARTMENT		Registered No. 66 06571	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) KATHERINE L. THOMAS				2. DATE AND HOUR OF DEATH 6/28/66 8 20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL		(If not in hospital or institution, give street address or location) BALTIMORE, MARYLAND-21202		A. STATE MARYLAND		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE-21218 9-01			
				D. STREET ADDRESS (If rural, give location) 3826 YOLANDO RD.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 7/4/1986	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM HUNDERTMARK				14. MOTHER'S MAIDEN NAME JULIA WILHELM			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. GEO. WILTON - 3826 YOLANDO RD		ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CORONARY THROMBOSIS ARTERIO SCLEROTIC HEART DISEASE				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/27 1966 to 6/28 1966 , that (I) (we) last saw the deceased alive on 6/28 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Martin C. Shargel				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/28/66	
23C. PHYSICIAN'S NAME (Type) MARTIN C. SHARGEL				23D. ADDRESS MARYLAND GENERAL HOSPITAL, BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/30/66		24C. NAME OF CEMETERY or CREMATORY LOZRAINE CEMETERY		24D. LOCATION (City, town, or county) (State) WOOD LANE MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR JUN 29 1966 Robert E. Farber		25C. FUNERAL DIRECTOR ULLRICH FUNERAL HOME - 4211 BELAIR RD		ADDRESS	

DATE: 4. 19. 1941

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E-560

66 06572

BALTIMORE CITY HEALTH DEPARTMENT

66 06572

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) NELSON A. EMERY				2. DATE AND HOUR PRONOUNCED DEAD June 28, 1966 10:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6310 Harford Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 13, 1901	9. AGE (In years last birthday) 65	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer		10B. KIND OF BUSINESS OR INDUSTRY Martin Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Arthur M. Emery				14. MOTHER'S MAIDEN NAME Jennie Streb			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-9980		17. INFORMANT ADDRESS Mrs. Jennie Beever 6310 Harford Road			
18. 422.1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 8/ 1/66		23C. NAME of CEMETERY or CREMATORY Oak Lawn		23D. LOCATION (City, town, or county) (State) Colgate, Md.	
24A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		24B. NAME OF REGISTRAR R. E. E. Farkas		24C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 4210 Belair Road,			

VALLEY POLICE

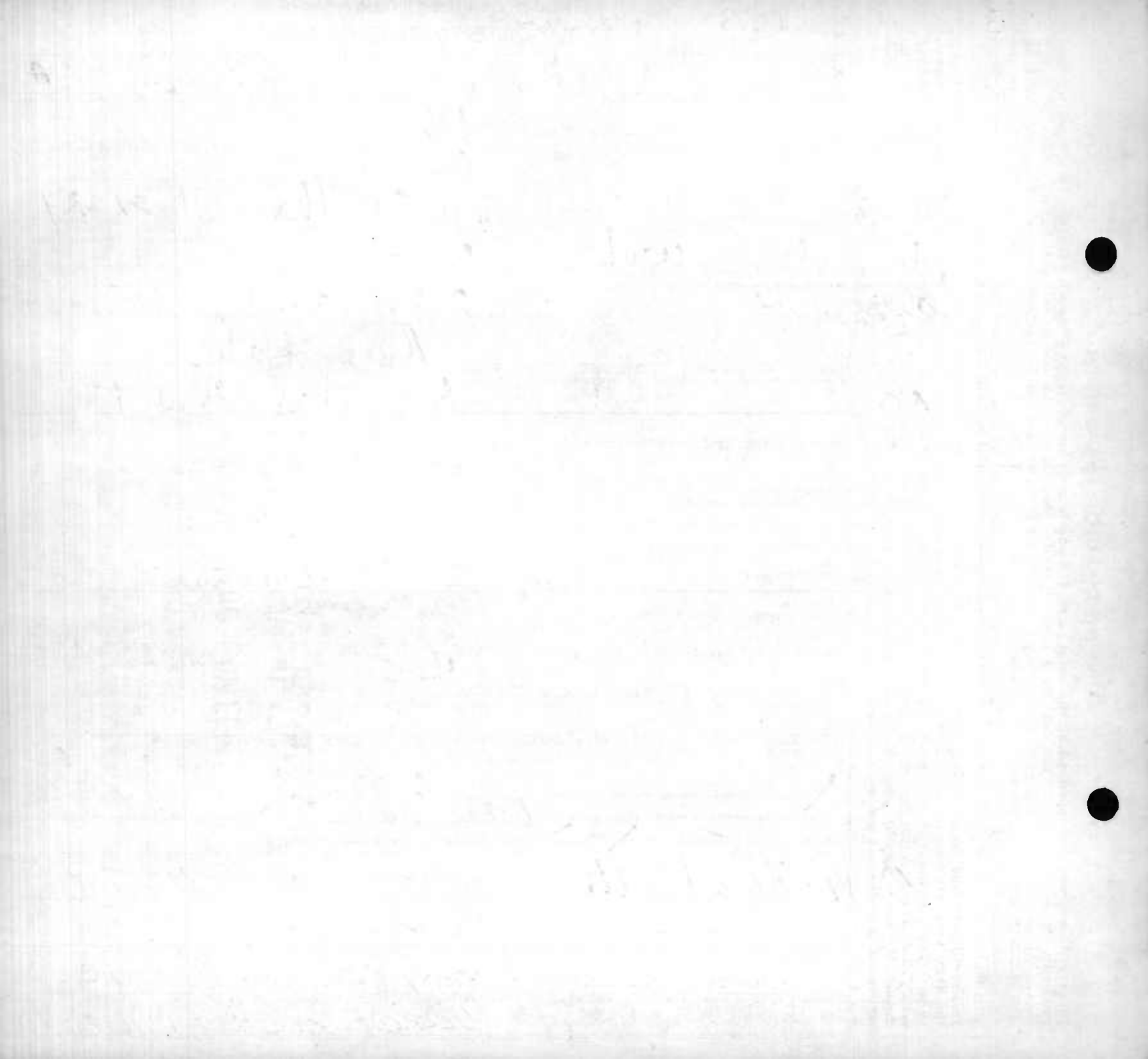
CRIMINAL DIVISION

1-2-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06573				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06573	
M.E. CASE NO. PERKNA				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Minnie Perkna				2. DATE AND HOUR OF DEATH 6-27-66 6^{PM}			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital				A. STATE MD. B. COUNTY			
5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-07			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				D. STREET ADDRESS (If rural, give location) 616 S Oldham St 21224			
10B. KIND OF BUSINESS OR INDUSTRY				8. DATE OF BIRTH 1-23-95		9. AGE (In years last birthday) 71	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
13. FATHER'S NAME John Benyes				14. MOTHER'S MAIDEN NAME Mary Hale			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. ?		17. INFORMANT Hospital Chart ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(A) Intestinal infection (B) Arteriosclerosis of mesenteric artery with probable thrombosis (C) Hypertensive cardiovascular disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nubly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-27-66 to 6-27-66 , that (I) (we) last saw the deceased alive on 6-27-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE D. Lindenstruth M.D.				23B. DATE SIGNED 6-27-66		23C. PHYSICIAN'S NAME (Type) D. LINDENSTRUTH M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-30-66		24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE COUNTY, MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966		25B. NAME OF REGISTRAR Club 2. J. J. J.		25C. FUNERAL DIRECTOR ULRICH FUNERAL HOME, DUNDALK, MD.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06574	
BIRTH NO. 66 06574		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Fred Vananzo		2. DATE AND HOUR OF DEATH 6/28/66 11 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Union Memorial Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00			
		D. STREET ADDRESS (If rural, give location) 3315 Appleton Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/29/92	9. AGE (In years last birthday) 74 yrs	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10B. KIND OF BUSINESS OR INDUSTRY CITY		11. BIRTHPLACE (State or foreign, country) California	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Vananzo		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-16-8160		17. INFORMANT ADDRESS Mrs Mary Vananzo 5421 Radetke Ave.	
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pneumonia DUE TO (B) Cerebral Thrombosis DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 6/26/66 to 6/28/66 , that (A) (we) last saw the deceased alive on 6/28/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.					
23A. SIGNATURE HARRY J. BROWN M.D.				23B. DATE SIGNED 6/28/66	
23C. PHYSICIAN'S NAME (Type) HARRY J. BROWN				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/66		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery Balto., Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUN 29 1966			
25B. NAME OF REGISTRAR Robert E. Tolson		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. 21214			

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Lander Thomas

2. DATE AND HOUR PRONOUNCED DEAD

6/25/66

11 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1423 Darley Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

M

6. RACE

C

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

7/7/09

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N. Carolina

12. CITIZEN OF
WHAT COUNTRY?
U.S.A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-09-9601

17. INFORMANT

ADDRESS

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/26/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/29/66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

JUN 30 1966

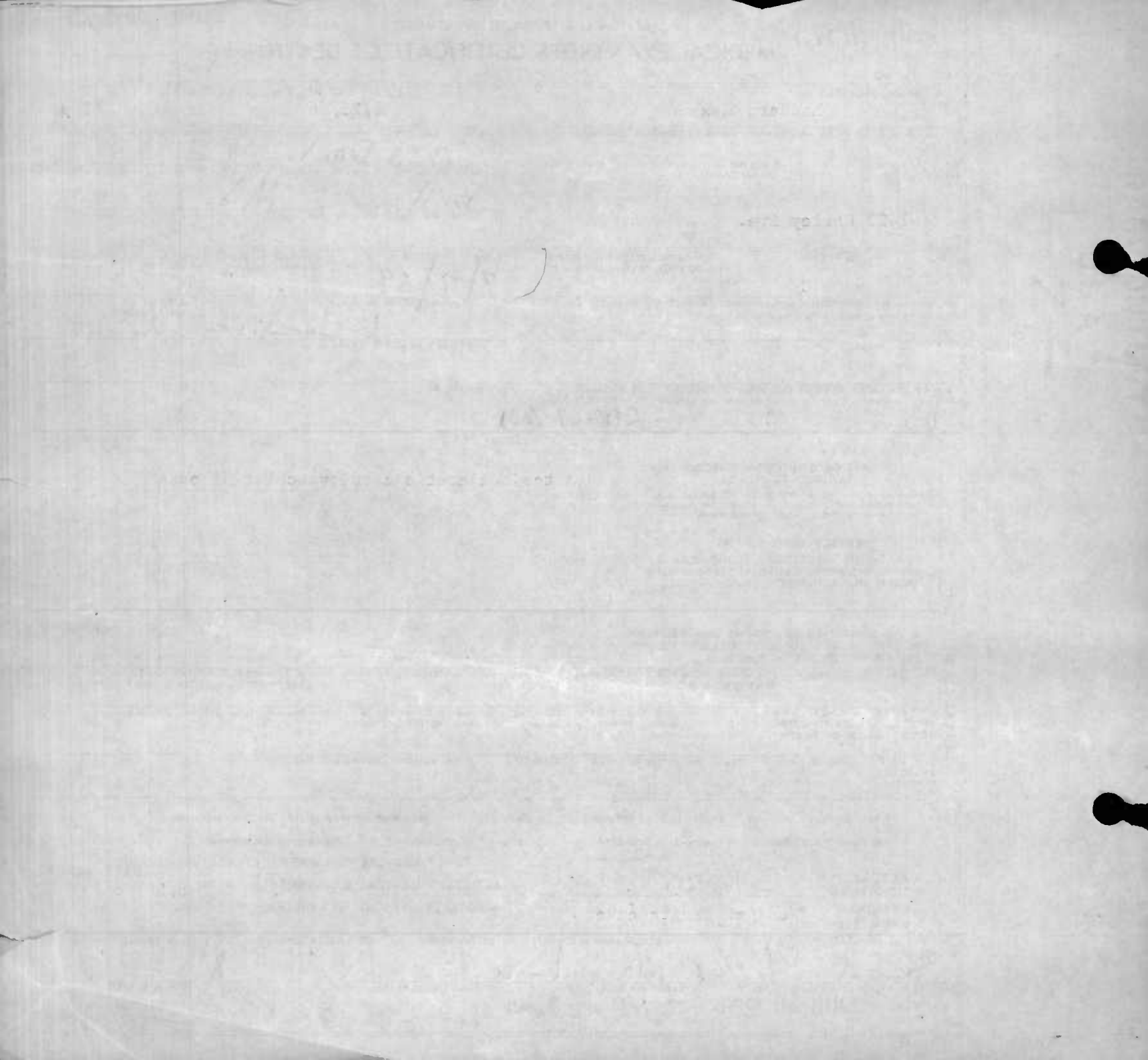
24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

L. P. Court 1712 W. North Ave

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06576</u>	
BIRTH NO. <u>66 06576</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Otis Stewart (Seward)</u>		2. DATE AND HOUR OF DEATH <u>June 23, 1966</u> <u>2:25p m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1103 Parrish St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>single</u>	8. DATE OF BIRTH <u>Dec. 16, 1920</u>	9. AGE (In years last birthday) <u>46</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Norfolk, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>233-1136</u> <u>Nevolia Thomas-2520 W. Baltimore Street</u>	
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Cerebral and Vascular Accident</u> (B) DUE TO <u>Probably due</u> (C) <u>Intracranial hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>no</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 22, 1966</u> to <u>June 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 23, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Glodys St. Phard</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>June 24, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Glodys St. Phard</u>		23D. ADDRESS M.D. <u>1514 Division Street-Baltimore, Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/28/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Tankey, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Abington S. Phillips 1727 N. Monroeville</u>			

Washington, Virginia 22114

Dec. 10, 1960

Dear Mr. [unclear]

Re: [unclear]

[unclear]

Unknown

Unknown

Very truly yours,

cc

cc

June 25, 1960

June 25, 1960

1960

1960

F 432

66 06577

BALTIMORE CITY HEALTH DEPARTMENT

66 06577

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Isaac FLETCHER

2. DATE AND HOUR PRONOUNCED DEAD

June 25, 1966 5:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Unknown

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3/6/1922

9. AGE (In years
last birthday)

44

10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charlie Weldon

14. MOTHER'S MAIDEN NAME

Geneva Fletcher

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

238-16-8740

17. INFORMANT

Lais Fletcher

ADDRESS

Same

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Gunshot wounds of head and neck
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Pavement

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

In front of 1326 1/2 N. Fulton Avenue

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
June 25, 1966 4:30 or 5:00 A.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

R. Breitenacker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 25, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/29/66

23C. NAME of CEMETERY or CREMATORY

Carmel Mem. Ph.

23D. LOCATION

Laurel

(City, town, or county)

Md.

24A. DATE REC'D BY HEALTH DEPT.

June 30, 1966

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Curlington S. Phillips 1727 N. Mount St.

ADDRESS

VALLEY POLICE

100-100

1-13-0

100-100

John Hall, Jr. to John Hall, Jr.

100-100

1-13-0

100-100

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 06578	
BIRTH NO. 66 06578				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>Beatrice Talley</u>	
2. DATE AND HOUR OF DEATH <u>6/22/66</u> <u>6:30 P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>3017 Belmont Avenue Baltimore, Maryland 21216</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>	
5. SEX <u>Female</u> 6. RACE <u>Negro</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
8. DATE OF BIRTH <u>Nov. 14, 1900</u> 9. AGE (In years last birthday) <u>65</u>				D. STREET ADDRESS (If rural, give location) <u>3017 Belmont Avenue</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur Burrs</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Shipley</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mildred Johnson</u> ADDRESS <u>3017 Belmont Avenue</u>					
18. <u>420.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Anterolateral Heart Disease one year</u>				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Uremia due to Chronic Nephritis</u>				<u>1 1/2 yrs</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>August 17, 1964</u> to <u>June 22, 1966</u> , that (I) (we) last saw the deceased alive on <u>June 21, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Roland T. Smoot</u> M.D.				23B. DATE SIGNED <u>6/23/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROLAND T. SMOOT, M.D.</u>				23D. ADDRESS <u>3817 COPLEY RD., BALTO. 15, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-27-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. STATE <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips</u> ADDRESS <u>1727 No Monroe Street</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06579		CERTIFICATE OF DEATH		Registered No. 66 06579	
1. NAME OF DECEASED (Type or Print) Van Bazemore				2. DATE AND HOUR OF DEATH 6-26-66 12:30 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1313 N. Monroe Street Baltimore, Maryland 21217				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1313 N. Monroe Street					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept. 1, 1899	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Bazemore			14. MOTHER'S MAIDEN NAME Unknown						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215-05-0124A		17. INFORMANT ADDRESS Mrs. Annabell Murray 604 Woodington Road				
18. 331 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertension DUE TO Cerebro-vascular Accident				INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 6 hrs.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 19 65 to June 19 66 , that (I) (we) last saw the deceased alive on 25 June 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Joshua R. Mitchell III M.D.						23B. DATE SIGNED 28 June 66			
23C. PHYSICIAN'S NAME (Type) Joshua R. Mitchell III M.D.						23D. ADDRESS 2202 Garrison Blvd. Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6-29-66			24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park			
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			24E. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe St.						
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR Robert E. Farley			25C. FUNERAL DIRECTOR			

JUN 30 1966

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 06580		CERTIFICATE OF DEATH				Registered No. 66 06580			
1. NAME OF DECEASED (Type or Print) <i>Barbara Januskas</i>					2. DATE AND HOUR OF DEATH <i>6/27/66</i> <i>4:45 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Middtown Home, Inc.</i> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>808 St. Paul Street Baltimore, Md., 21202</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> Pr. Geo. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Colmar Manor</i> D. STREET ADDRESS (If rural, give location) <i>3301 - 40th Place</i>				
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>12/4/86 1890</i>	9. AGE (In years lost birthday) <i>75</i> <i>77</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>	12. CITIZEN OF WHAT COUNTRY? <i>Lithuania</i>
13. FATHER'S NAME <i>Adam Yurgitis</i>					14. MOTHER'S MAIDEN NAME <i>Unknown</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Thomas Januskas (above address)</i>				ADDRESS
18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cardio-Respiratory Failure</i>			CAUSE OF DEATH (Husband) <i>Massive Cerebral Hemorrhage</i> <i>Idiopathic Epilepsy</i>			INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1961</i> to <i>June 27, 1966</i> , that (I) (we) last saw the deceased alive on <i>June 27, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE <i>William Applefeld</i> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <i>William Applefeld</i>					23D. ADDRESS M.D. <i>5501 Park Heights Dr.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/29/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Olivet Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1966</i>			25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Walley's Funeral Home Inc.</i>		ADDRESS <i>Mt. Rainier, Md.</i>		

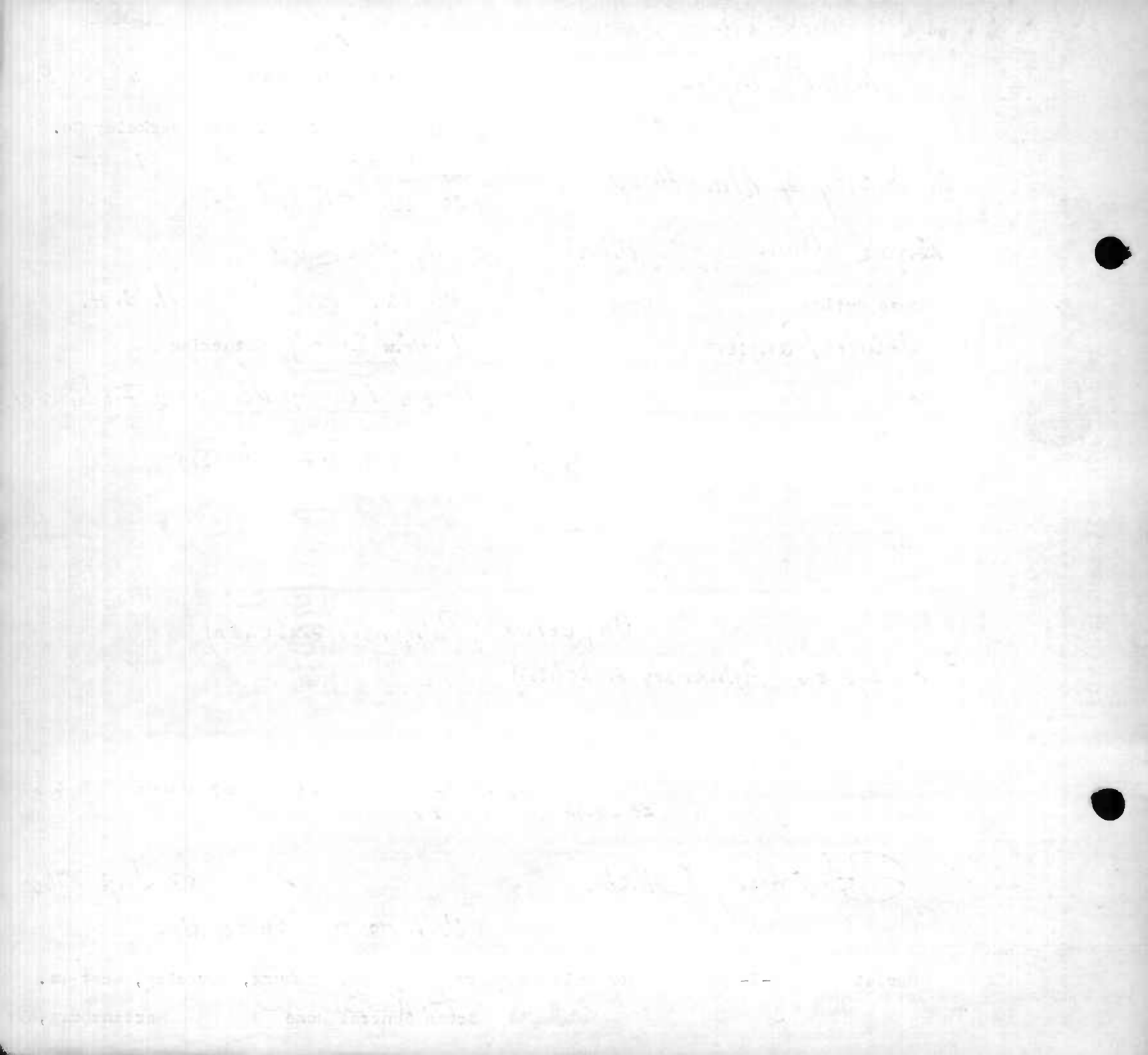
X

[Faint, illegible handwritten text covering the page]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

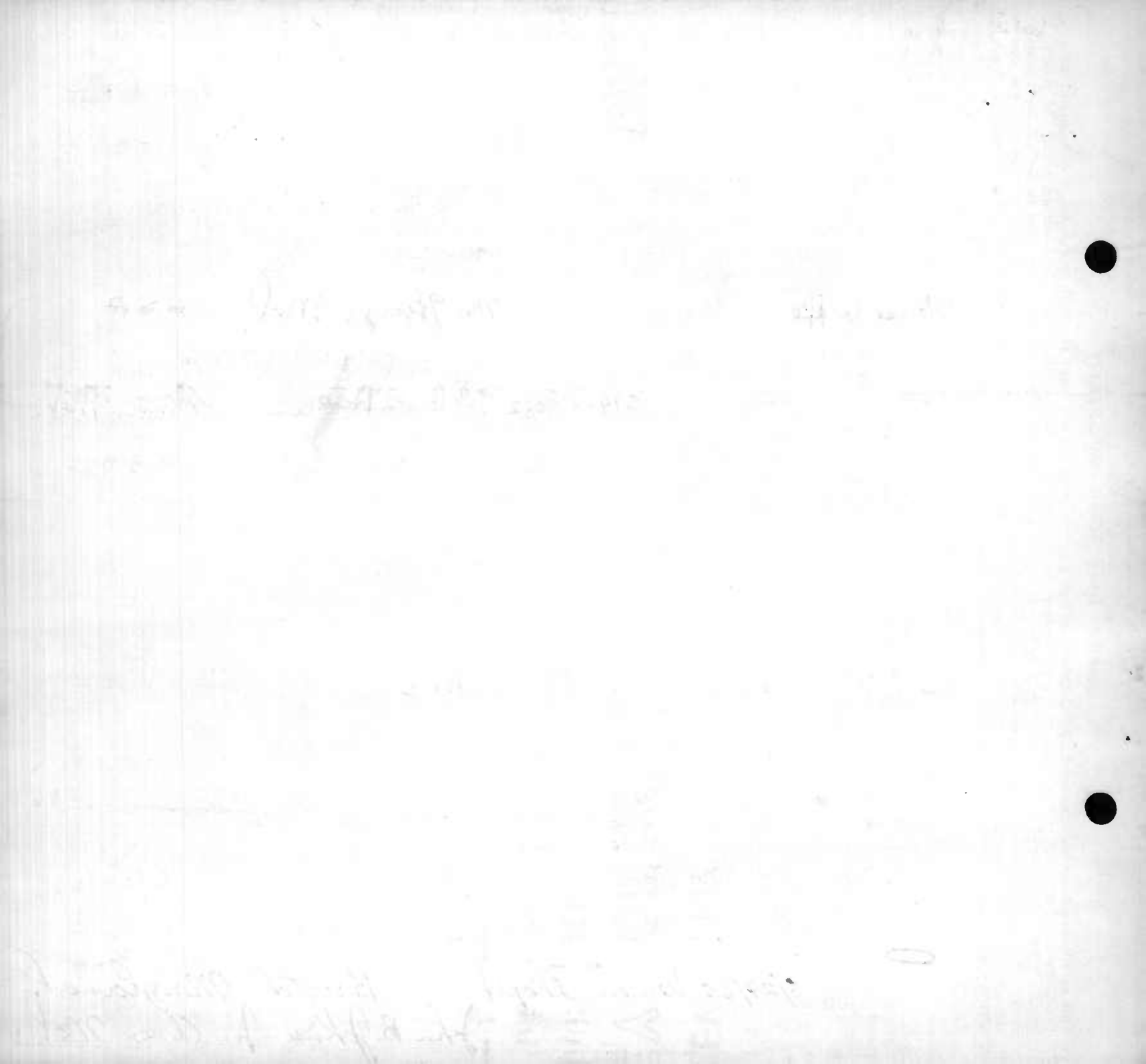
BIRTH NO. 66 06581		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06581	
M.E. CASE NO.		CERTIFICATE OF DEATH		2	
1. NAME OF DECEASED (Type or Print) Ellen Myers		2. DATE AND HOUR OF DEATH 28 June 1966		6:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE W. Va. B. COUNTY Martinsburg Berkeley Co.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Md. Hosp. 38		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Martinsburg V-45		D. STREET ADDRESS (If rural, give location) 120 W. Stephen St.	
5. SEX Male	6. RACE Cau.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 18 July 1902	9. AGE (In years last birthday) 63	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) W. Va.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles Painter		14. MOTHER'S MAIDEN NAME Dillow Sarah Catherine	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Hallie Tuminello 1020 Fredonia Ct.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO ? Acute pulmonary embolism			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION 18 June 66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary embolism		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 18 June 1966 to 28 June 1966, that (I) (we) lost saw the deceased alive on 28 June 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.				23B. DATE SIGNED 28 June 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. Univ. Hosp. Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-1966		24C. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery	
24D. LOCATION Martinsburg, Berkeley, West Va.		25A. DATE REC'D BY HEALTH DEPT JUN 30 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H. H. Brown		ADDRESS Martinsburg, W. Va.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

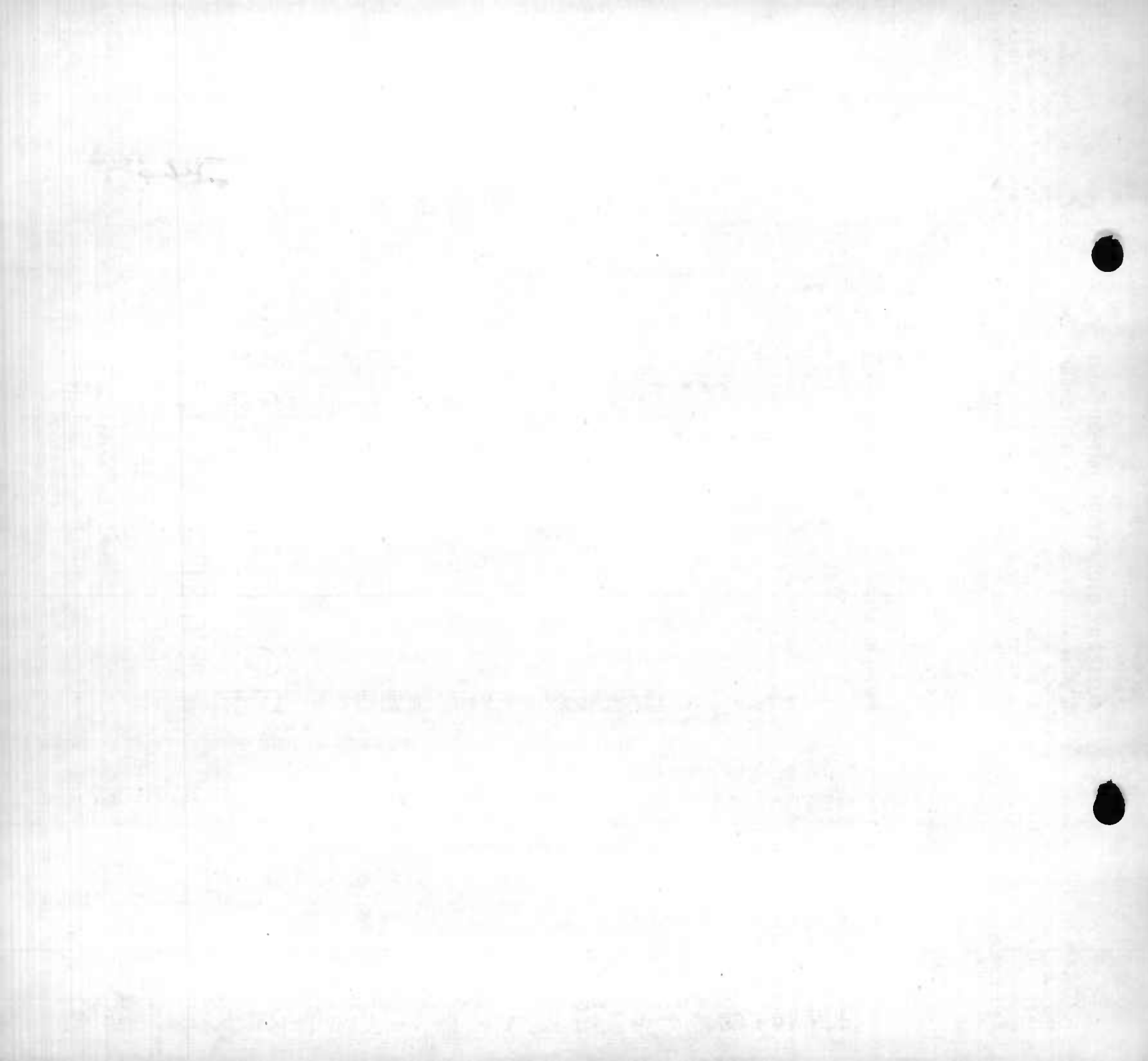
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 06582		CERTIFICATE OF DEATH				Registered No. 66 06582			
M.E. CASE NO.					DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) IDA TURPIN					6-26-66 2.20 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33					A. STATE MARYLAND B. COUNTY A.A. 52-10				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) ANNAPOLIS				
					D. STREET ADDRESS (If rural, give location) 16 FLEET STREET				
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-11-12	9. AGE (in years lost birthday) 53	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wiffo			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mc. Henry, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN WISEMAN			14. MOTHER'S MAIDEN NAME GEORGIA WHITTINGTON						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —			16. SOCIAL SECURITY NO. 214-18-9032		17. INFORMANT Helen Brown		ADDRESS Ann. Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 15381 CAUSE OF DEATH (A) Carcinoma Colon DUE TO					INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 3 6/2/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction secondary to carcinoma colon			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (this hospital) attended the deceased from 5-21 1966 to 6/26 1966, that (I) last saw the deceased alive on 22 AM 6/26 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.									
23A. SIGNATURE Jerry S. Dorman					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 6/26/66	
23C. PHYSICIAN'S NAME (Type) JERRY S. DORMAN					23D. ADDRESS Johns Hopkins Hosp				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JUN 26/29/66		24C. NAME of CEMETERY or CREMATORY Union Chapel		24D. LOCATION (City, town, or county) (State) Bristol Maryland			
25A. DATE REC'D FOR DEATH JUN 26 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR John B. Johnson Jr. Ann. Md.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06583</u>	
BIRTH NO. <u>66 06583</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LENA HILDEBRANDT</u>		2. DATE AND HOUR OF DEATH <u>June 28, 1966</u> <u>12:40 P. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>1926 E. MADISON ST.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>7-05</u> D. STREET ADDRESS (If rural, give location) <u>1926 E. Madison St.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 6, 1892</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>CARL Leissfeld</u>		14. MOTHER'S MAIDEN NAME <u>Lena Miller</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Louise Jones</u> ADDRESS <u>1926 E. Madison St.</u>	
18. <u>7-00-1-260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Coronary Occlusion</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <u>ARTERIOSCLEROSIS</u> <u>OLD AGE + DIABETES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>None</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>	
21D. TIME OF INJURY (APPROX.) <u>None</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> <u>None</u> <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>None</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1965</u> to <u>JUNE 28 1966</u> , that (I) <u>we</u> last saw the deceased alive on <u>JUNE 15 1966</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles P. Crim</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6/29/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHARLES P. CRIM M.D.</u>		23D. ADDRESS <u>2722 E. MONUMENT ST BALTO MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/1/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>Philip E. Crach</u> ADDRESS <u>1211 Chesapeake Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06584		CERTIFICATE OF DEATH		Registered No. 66 06584	
1. NAME OF DECEASED (Type or Print) HELENA L. BUSCHMANN				2. DATE AND HOUR OF DEATH 6-28-66 0825 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 24-03 D. STREET ADDRESS (If rural, give location) 1129 BATTERY AVE.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-25-07		9. AGE (In years last birthday) 58		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY At Home			11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John T. Selway			14. MOTHER'S MAIDEN NAME Cora Eisel						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Family - Same			ADDRESS	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH ?					
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 6-28-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 0725 6-28 1966 to 0825 6-28 1966 , that (I) (we) lost saw the deceased alive on 6-28 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Eldon Hawbakker				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-28-66			
23C. PHYSICIAN'S NAME (Type) ELDON HAWBAKKER				23D. ADDRESS MERCY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7 2 66		24C. NAME OF CEMETERY OR CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR 130 E. Folsom Ave.		ADDRESS			

1124 Battery Ave
Mercy Hospital
Baltimore

F W
Mailed 12-22-07

Myosotis laxa

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Edon Howard
John Howard

Myosotis laxa

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06585		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06585	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BURKINS, MARGARET		2. DATE AND HOUR OF DEATH 6:40 AM 28 Jun 66 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION U. of Maryland		A. STATE MD. B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) Spring Grove State Hosp.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 8-27-97	9. AGE (In years (last birthday)) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) YORK CO, PA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Franklin Reath		14. MOTHER'S MAIDEN NAME Mary GARVINE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mrs. Margaret Sliver Aberdeen MD.	
18. 450.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Septicemia		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Gangrene Rt. leg			
		(B) DUE TO Arteriosclerosis			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-26-66 19 to 6-28-66 19, that (I) (we) last saw the deceased alive on 6-28 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE T. G. DODENHOFF M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) T. G. DODENHOFF M.D.		23D. ADDRESS University Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUL 1 1966		24C. NAME OF CEMETERY or CREMATORY Fawn Grove Cemetery	
24D. LOCATION (City, town, or county) (State) PA					
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Rene W. Osburn Stewarttown PA.	

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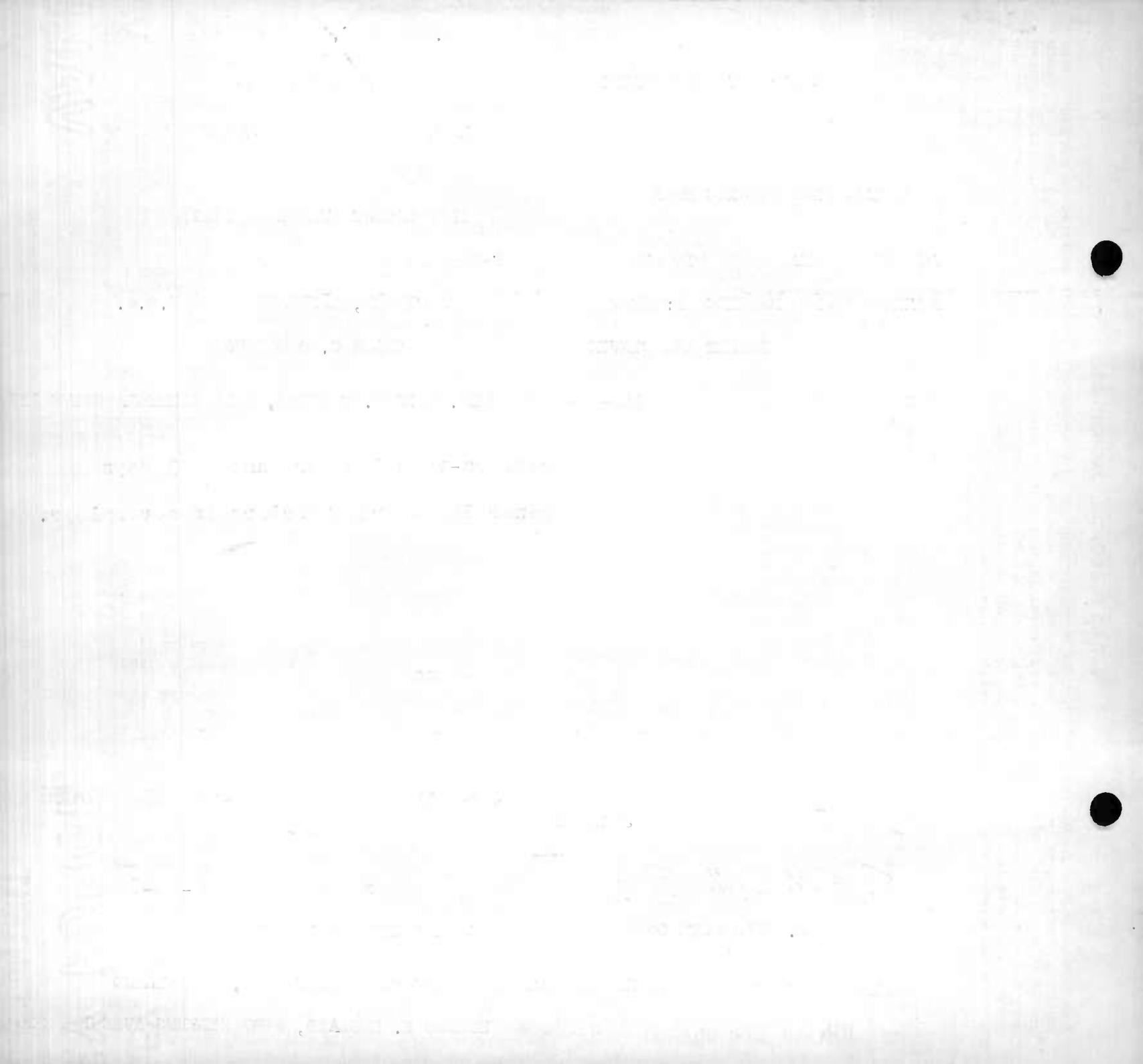
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																													
66 06586					CERTIFICATE OF DEATH					Registered No. 66 06586																			
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH														
					ELLEN CATHERINE HARRIS					JUNE 27, 1966					M.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)																			
FULL NAME OF HOSPITAL OR INSTITUTION					(If not in hospital or institution, give street address or location)					A. STATE					B. COUNTY														
90 BOLTON HILL NURSING HOME										MARYLAND					BALTIMORE -53-00														
										C. CITY OR TOWN (If outside city limits, write RURAL and give township)																			
										ARBUS																			
										D. STREET ADDRESS (If rural, give location)																			
										1249 LOCUST AVENUE 21227																			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.																	
FEMALE		WHITE		WIDOWED		2-27-1891		75																					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10B. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?													
RETIRED SEWING MACHING OPERATOR												BALTIMORE, MARYLAND				U.S.A.													
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME																			
ROBERT LEE GIRVIN										ELLEN C. O'DONOVAN																			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS																			
NO					220-18-3814					MRS. LOIS A. TRAVERS, 4824 CARMELLA DRIVE #27																			
18. <u>321X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH														
										(A) cerebro-vascular accident					3 days														
										(B) generalized arteriosclerosis					several yrs														
										(C)																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
																				no									
										21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
										21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from June 13 1966 to June 27 1966, that (I) (we) last saw the deceased alive on June 26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															23A. SIGNATURE					23B. DATE SIGNED									
										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>					6-28-66														
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS																			
E. ELLSWORTH COOK										M.D. 2431 MARYLAND AVENUE																			
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE			24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)																				
BURIAL			6-30-66			BALTIMORE NATIONAL CEMETERY			BALTIMORE, MARYLAND																				
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS																				
JUN 30 1966			Robert E. Farley, M.D.			HOWARD H. HUBBARD			4107 WILKENS AVENUE 21229																				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06587</u>	
BIRTH NO. <u>66 06587</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <u>John Nicholas</u>		
2. DATE AND HOUR OF DEATH <u>6-28-66</u> <u>11:25 P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 Church Home & Hosp</u>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
			D. STREET ADDRESS (If rural, give location) <u>1714 FLEET ST. 31</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>6/19/66</u>	9. AGE (In years last birthday) <u>63</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal Polisher</u>			11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Nicholas</u>			14. MOTHER'S MAIDEN NAME <u>NINA MARTIN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chart</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute myo cardiac infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-24-66</u> to <u>6-28-66</u> , that (I) (we) lost saw the deceased alive on <u>6-28-66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>D. A. E. SUBONG</u>				23D. ADDRESS <u>Church Home & Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Rosedale Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Linden, New Jersey</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc. 1217 St. Paul St. 212022</u>	

1
M-620

66 06588

BALTIMORE CITY HEALTH DEPARTMENT

66 06588

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VIOLA MARIS

2. DATE AND HOUR PRONOUNCED DEAD

June 28, 1966

8:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MERCY HOSPITAL

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

808 St. Paul Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

8/20/20

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

August Maris

14. MOTHER'S MAIDEN NAME

Constance Perkos

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-16-5918

17. INFORMANT

Nursing Home

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-29-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/30/66

23C. NAME of CEMETERY or CREMATORY

Greek Orthodox Cemetery

23D. LOCATION

(City, town, or county)

Baltimore County, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 30 1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202

ADDRESS

WALLER FONGE

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

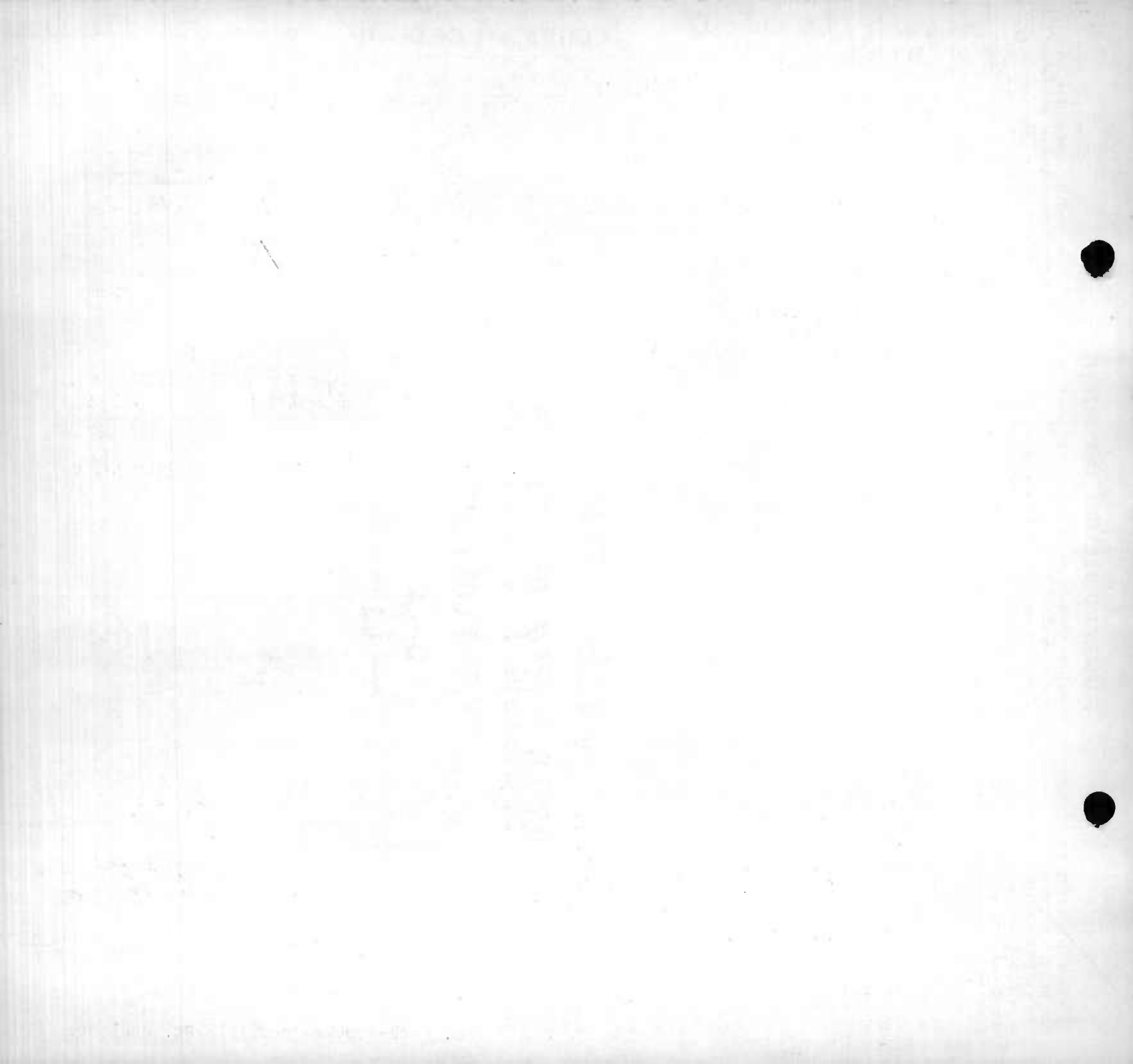
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65589</u>	
BIRTH NO. <u>66 06589</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MARY MARGARET GARLAND			2. DATE AND HOUR OF DEATH Xx 6/26/66		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 403 Sanders St Baltimore, Md. 21230			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 403 Sanders St.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/4/90	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William Carmine		
14. MOTHER'S MAIDEN NAME Florence (Unknown)			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 214-20-65743			17. INFORMANT Husband- Leo Garland 403 Sanders St Balt. Md.		
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ante Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic arteriosclerotic Heart Disease					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 19 65</u> to <u>June 10 1966</u> , that (I) (we) last saw the deceased alive on <u>June 10 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Ricardo Lozada				23B. DATE SIGNED 6/27/66	
23C. PHYSICIAN'S NAME (Type) RICARDO LOZADA				23D. ADDRESS 1228 S. Charles St. Balt. 31, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/66		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Catonsville, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR 1217 St. Paul St. ADDRESS Wm. Cook-Brooks Inc. Baltimore, Md. 21202			

46-95655-55
JJ

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

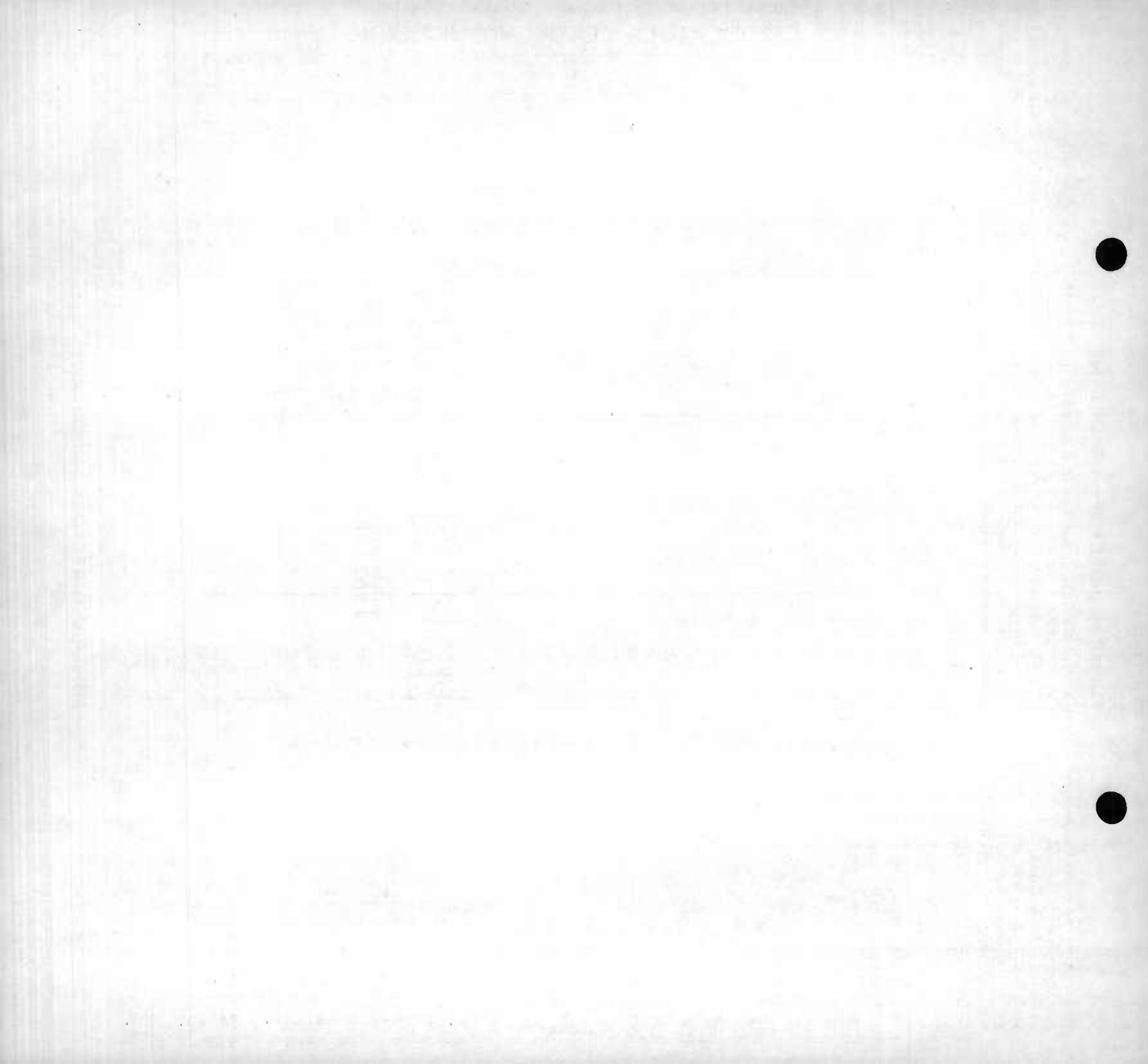
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06590	
BIRTH NO. 66 06590		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mary L Hammar		2. DATE AND HOUR OF DEATH 6/28/66 1 17 ²⁵ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		A. STATE Md B. COUNTY X			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 10-02		D. STREET ADDRESS (If rural, give location) 942 Ashland Ct. 21202			
5. SEX F	6. RACE Cauc	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 12-7-86	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME John M. Hammar		14. MOTHER'S MAIDEN NAME William Brownings			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT BCH RECORDS: 4940 EASTERN AVE. #21224 Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Sigmoid Tumor (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		multiple CVAs		years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/13 19 66 to 6/28 19 66, that (I) (we) last saw the deceased alive on 6/28 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alan E. Oestrich		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/28/66	
23C. PHYSICIAN'S NAME (Type) DR. ALAN E. OESTRICH		23D. ADDRESS Baltimore City Hospitals 4940 EASTERN AVE. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/66		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06591				BALTIMORE CITY HEALTH DEPARTMENT		Certificate of Death		Registered No. 66 06591	
1. NAME OF DECEASED (Type or Print) JOSEPH CHARLES KIEL					2. DATE AND HOUR OF DEATH 6/26/66 8:00 PM.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY XXXXXXXXXX C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 22-02 D. STREET ADDRESS (If rural, give location) 332 WEST CAMDEN STREET				
5. SEX MALE	6. RACE WH	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH NOV 5, 1908	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER			10B. KIND OF BUSINESS OR INDUSTRY Codd Bakers Inc.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOSEPH A. KIEL					14. MOTHER'S MAIDEN NAME NELLIE L. HUTCHISON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II ?			16. SOCIAL SECURITY NO. 216-03-1567		17. INFORMANT ADDRESS John Kiel, 1428 Bruning Hgwy. Balto., Md.				
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH THREE WEEKS 6-6-66				
19A. DATE OF OPERATION 6/20/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/6 19 66 to 6/26 19 66 , that (I) (we) last saw the deceased alive on 6/26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Margaret E. Lang, MD					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6/26/66	
23C. PHYSICIAN'S NAME (Type) MARGARET E. LANG, MD					23D. ADDRESS UNIVERSITY HOSPITAL, BALTIMORE, MARYLAND				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-66		24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966			25B. NAME OF REGISTRAR P. B. E. Farley			25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc., Balto., Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 66 06592					CERTIFICATE OF DEATH					Registered No. 66 06592						
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH											
HARRY EVERT MONROE					6/29/66					9 AM M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1920 Griffis Ave Baltimore, Md. 21230					A. STATE Md					B. COUNTY						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 1920 Griffis Ave						
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 6/1/01		9. AGE (In years last birthday) 65		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed					10B. KIND OF BUSINESS OR INDUSTRY Tavern Owner					11. BIRTHPLACE (State or foreign country) St. James, Missouri					12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward H. Monroe					14. MOTHER'S MAIDEN NAME Helen M. Ness											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 112-07-3472					17. INFORMANT Edna May Monroe					1920 Griffis Ave ADDRESS Baltimore, Md. 21230	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) DUE TO Cer Pulmonale (B) DUE TO Pulmonary Emphysema (C) DUE TO Chronic Bronchitis					INTERVAL BETWEEN ONSET AND DEATH Sudden 5 years 5 years						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Right nephrectomy					Carcinoma					Dec 1966	
19A. DATE OF OPERATION May 1965					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gall stone					20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 3/28 19 66 to 6/29 19 66, that (I) (we) last saw the deceased alive on 6/24 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
23A. SIGNATURE John P. Urlock Jr					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 6/29/66						
23C. PHYSICIAN'S NAME (Type) JOHN P. URLOCK JR					M.D. 1227 WASH. BLVD											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 7/1/66					24C. NAME OF CEMETERY or CREMATORY Loudon Park					24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966					25B. NAME OF REGISTRAR Robert E. Fairman					25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc					1217 St. Paul St. ADDRESS Baltimore, Md. 21202	

THE
OFFICE OF THE
TREASURER

OF THE
UNITED STATES

DEPARTMENT OF THE TREASURY

WASHINGTON, D. C.

1900

Report of the
Treasurer
of the
United States
for the
Year
1900

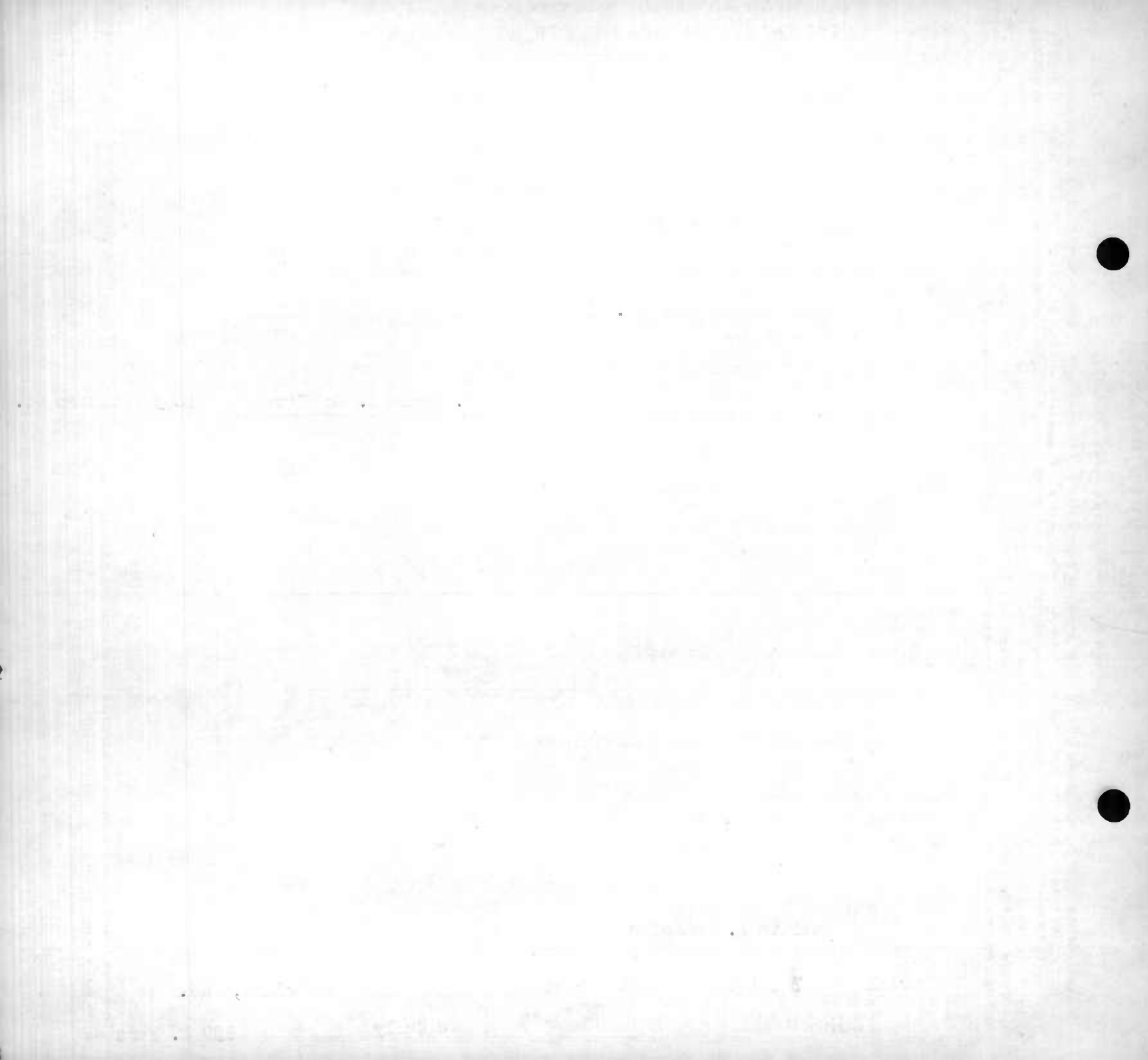
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>86645293</u>	
BIRTH NO. <u>66 06593</u>				1. NAME OF DECEASED <u>James J English</u>		2. DATE AND HOUR OF DEATH <u>6/29/66 5:30 PM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bolton Hill Nursing Home</u>				A. STATE <u>MD</u> B. COUNTY <u>XXXXX</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Lafayette + John St</u>				D. STREET ADDRESS (If rural, give location) <u>3507 N. Charles St.</u>		<u>12-02</u>	
5. SEX <u>Male</u> RACE <u>White</u>				6. DATE OF BIRTH <u>5/24/1876</u>		9. AGE (In years last birthday) <u>90</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Worcester, Mass</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>John English</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mrs. Rita G. Eastman</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coronary heart failure</u>				CAUSE OF DEATH (A) DUE TO <u>ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5.6 days</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>La pulmon. tuberculosis</u>		<u>years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>6-29-66</u> to <u>6-29-66</u> and that (2) (we) last saw the deceased alive on <u>6-29-66</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Koshi Nakazawa</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-29-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>KOSHI NAKAZAWA</u>				23D. ADDRESS <u>3350 Wilkens Ave. Baln 21229</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore County</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1966</u>				25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc.</u>	
				ADDRESS <u>1217 St/ Balt. Md.</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06594</u>	
BIRTH NO. <u>66 06594</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MC CLURE NELSON ELLWOOD JR</u>		2. DATE AND HOUR OF DEATH <u>6/28/66 1034</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSP</u>		A. STATE <u>MD.</u> B. COUNTY <u>23-02</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO</u>			
		D. STREET ADDRESS (If rural, give location) <u>1603 PATAPSCO STREET</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED/NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>YES</u>	8. DATE OF BIRTH <u>6 12 1902</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>NELSON E MCCLURE Sr</u>		14. MOTHER'S MAIDEN NAME <u>AGNES GORSLICH</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Sarah C. Mc Clure 1603 PatapSCO St.</u>	
18. <u>E951X1</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>PERUT HEPATITIS</u> DUE TO		<u>9-5 DAYS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>CA OF TONGUE</u> DUE TO		<u>2 YRS</u>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>23/9/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA of Tongue</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/23 1966</u> to <u>6/28 1966</u> , that (I) (we) last saw the deceased alive on <u>10:20 AM 6/26</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Dominic A. Culotta</u>				23B. DATE SIGNED <u>6/28/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dominic A. Culotta</u>				23D. ADDRESS <u>M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7 1 1966</u>		24C. NAME of CEMETERY or CREMATORY <u>East Market</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Mc Cully 130 E. Fort Av</u>	
		24D. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06595	
BIRTH NO. 66 06595		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MEWSHAW, WILLIAM I.		2. DATE AND HOUR OF DEATH 6. 25. 66 6:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 25-05		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland 46		D. STREET ADDRESS (If rural, give location) 3918 Pennington Ave			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Apr. 14, 1886	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Davison Chemical		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Enoch Mewshaw		14. MOTHER'S MAIDEN NAME Akshaw Clark	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) /?		16. SOCIAL SECURITY NO. 215-07-7882		17. INFORMANT Mrs. Emma Mewshaw - 3918 Pennington Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Pneumonia DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Atherosclerotic cardiovascular disease			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6. 19 1966 to 6. 25 1966, that (I) (we) last saw the deceased alive on 6. 25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) JOSEF GRUMBERG		M.D. Lutheran Hospital		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 28, 1966		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION Ritchie Hwy., A.A.Co., Maryland		24E. DATE REC'D BY HEALTH DEPT. JUN 30 1966		24F. NAME OF REGISTRAR Robert E. Fisher	
24G. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hwy., Baltimore		24H. ADDRESS			

1
6-360

66 06596

BALTIMORE CITY HEALTH DEPARTMENT

66 06596

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DONALD W. GAITHER Sr.

2. DATE AND HOUR PRONOUNCED DEAD

June 27, 1966

9:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1329 Smithson Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1100 Calhoun Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 21, 1934

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Stock Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin C. Gaither

14. MOTHER'S MAIDEN NAME

Catherine Fountain

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lorraine Gaither - 1710 Poplar Grove

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)(A) Fatty alteration of liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Partial

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-28, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-30-66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary

23D. LOCATION

(City, town, or county)

(State)

Brooklyn A.A.C. Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

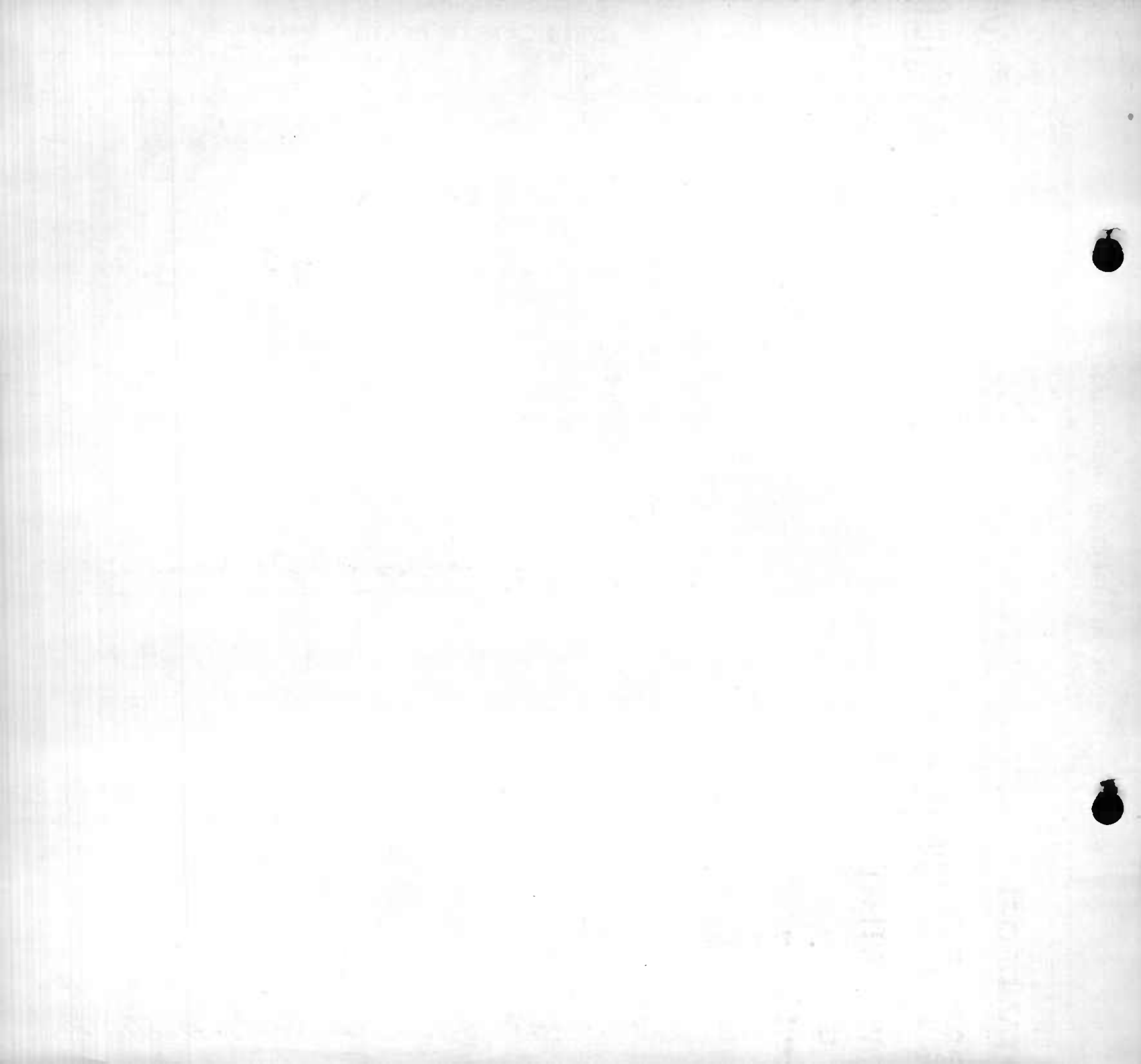
ADDRESS

WALTER POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

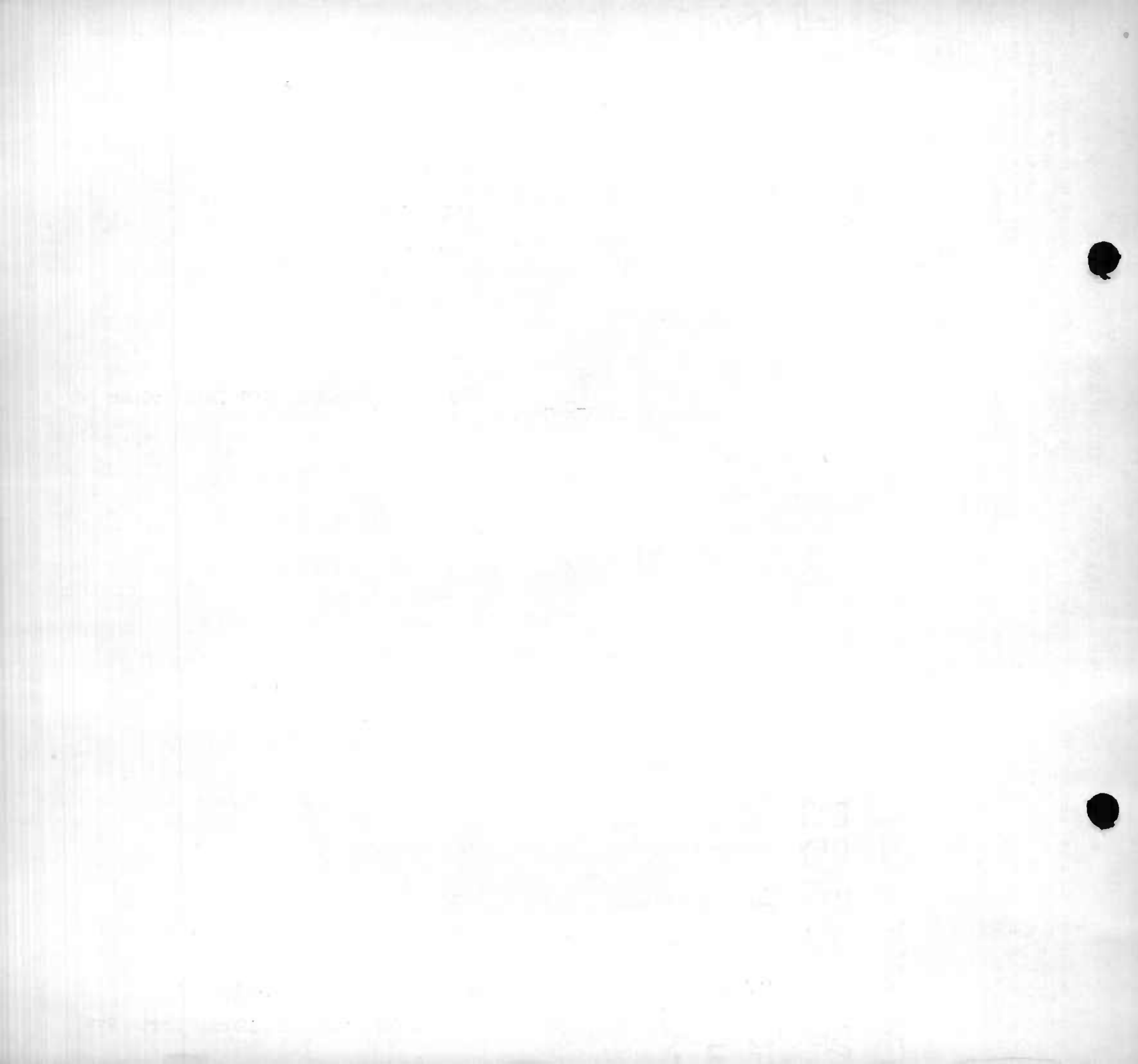
BALTIMORE CITY HEALTH DEPARTMENT										
66 06597					CERTIFICATE OF DEATH		Registered No. 66 06597			
BIRTH NO. 66 06597					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Clmina Beverly</i>					2. DATE AND HOUR OF DEATH <i>0430 AM 16/23/66 M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33 Johns Hopkins Hospital</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore City</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>5-01 102 Central Avenue</i>					
5. SEX <i>female</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>single</i>	8. DATE OF BIRTH <i>7/4/25</i>	9. AGE (In years lost birthday) <i>40</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Grumash Beverly</i>			14. MOTHER'S MAIDEN NAME <i>Rachel Rolling</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Rachel Clark-1926 E. Oliver ST.</i>			ADDRESS				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(A) DUE TO (B) DUE TO (C) <i>Ruptured Descend Cyst & ovarian formation + peritonitis</i>					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <i>6/23/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ruptured Descend Cyst & peritonitis</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (1) (this hospital) attended the deceased from <i>6/23</i> 19 <i>66</i> to <i>6/23</i> 19 <i>66</i> , that (1) (we) last saw the deceased alive on <i>6/27</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Tim H. Parmley</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>6/28/66</i>		
23C. PHYSICIAN'S NAME (Type) <i>Tim H. Parmley</i>					23D. ADDRESS <i>Johns Hopkins Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-2-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary</i>		24D. LOCATION (City, town, or county) (State) <i>Burklyn H. H. Co Md</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Darnell S. Oden - Balto. Md</i>		ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

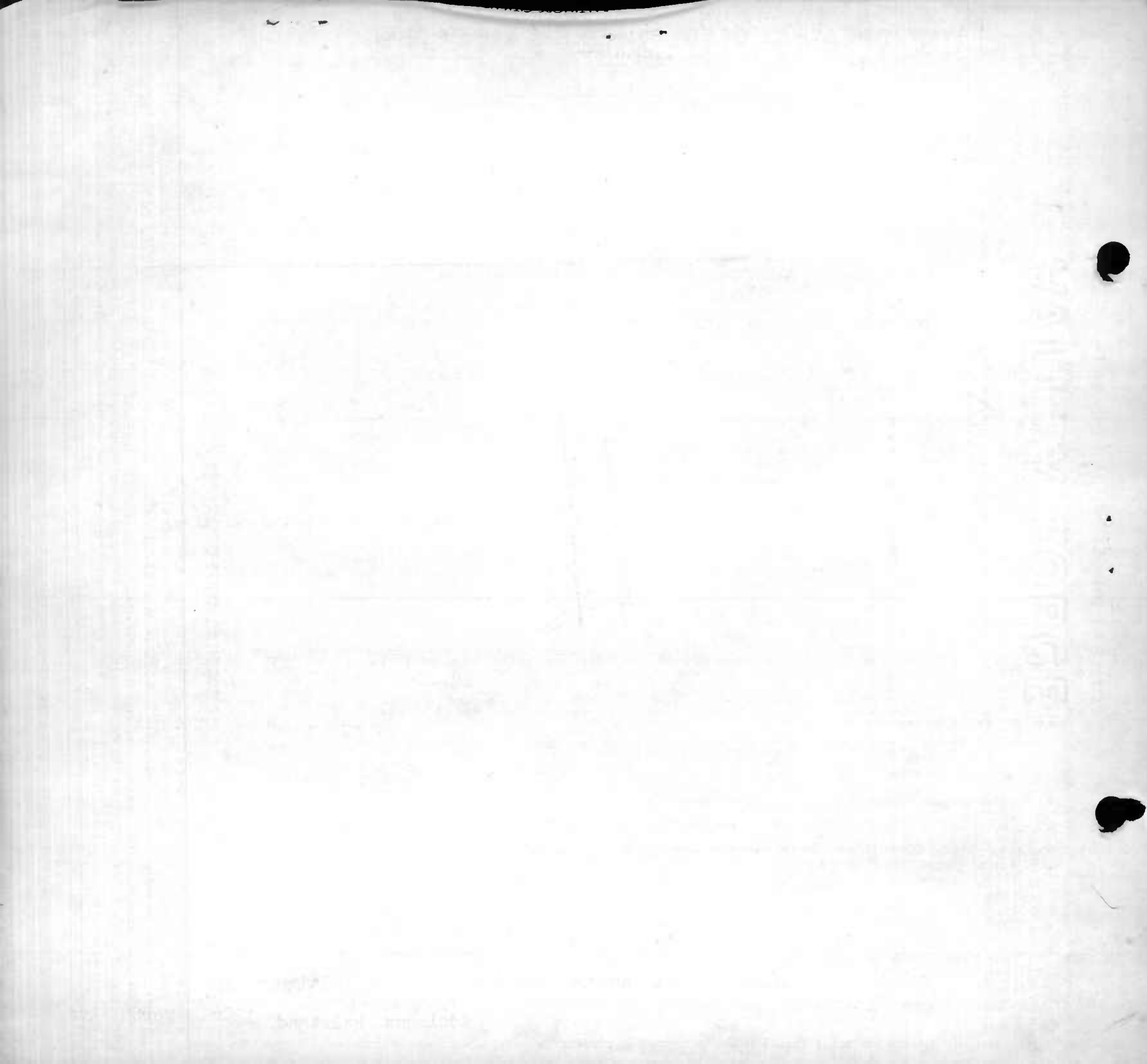
BIRTH NO. 66 06598		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06598	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) GEORGE GILBERT HALL (BUTLER)			2. DATE AND HOUR OF DEATH JUNE 28, 1966		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 831 Vine St			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 18-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 831 Vine St		
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 2/10/02	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME JOHN HALL		
14. MOTHER'S MAIDEN NAME MARY			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 216-01-2286			17. INFORMANT MRS MILDRED BRUCE 2401 Reistertown Rd		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. new			CAUSE OF DEATH (A) Coronary occlusion. DUE TO (B) Hypertensive Cardio Vascular D. DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH Snader ?		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from June 1 19 66 to June 24 19 66 , that (I) (we) last saw the deceased alive on June 24 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry Glassman M.D.			23B. DATE SIGNED July 1, 66		
23C. PHYSICIAN'S NAME (Type) HARRY GLASSMAN			23D. ADDRESS 712 W. Lupton St		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/66		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetry	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966			
25B. NAME OF REGISTRAR Paul E. Farley		25C. FUNERAL DIRECTOR ADOLPHUS HALSTEAD 1206 W North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06599				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06599	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JUANITA MARIE Hill				2. DATE AND HOUR OF DEATH 6-27-66 8:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 17-03			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.			
				D. STREET ADDRESS (If rural, give location) 745 W. FRANKLIN ST.			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED, DIVORCED (Specify) CHILD		8. DATE OF BIRTH 3-16-64	9. AGE (In years last birthday) 2	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10B. KIND OF BUSINESS OR INDUSTRY CHILD		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME VINCENT Hill				14. MOTHER'S MAIDEN NAME MARY LEE JOHNSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. CHART # 331245 (U.I.A.)		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL EDEMA				INTERVAL BETWEEN ONSET AND DEATH 4 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. LEAD ENCEPHALOPATHY				INTERVAL BETWEEN ONSET AND DEATH 5 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 745 W. Franklin St 17-03			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Unknown		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Eating plaster			
22. I certify that (He) (this hospital) attended the deceased from 6-22-66 to 6-27-66 and that (He) (We) last saw the deceased alive on 6-27-66 and that (He) (We) (our) opinion death occurred on the date and hour and from the causes stated above. (He) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Albert M. Gordon M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-27-66	
23C. PHYSICIAN'S NAME (Type) ALBERT M. GORDON M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/66		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetry		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave			



1
J-250

66 06600

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 06600

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BERNARD JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

June 27, 1966

11:30 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

222 N. Mount Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

222 N. Mount Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

6-19-1922

9. AGE (In years
lost birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CHAUFFEUR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James Jackson

14. MOTHER'S MAIDEN NAME

IDA JONES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Ida Jackson 222 N Mount St

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH(A) Fatty alteration of liver
DUE TO

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Partial

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-28-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7-1-1966

23C. NAME OF CEMETERY or CREMATORY

BALTO NATIONAL

23D. LOCATION

(City, town, or county)

(State)

BALTO MD

24A. DATE REC'D BY HEALTH DEPT.

JUN 30 1966

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Marshall P. Raper 638 N Gilmor St

ADDRESS

WALLER FORCE



66 06601

BALTIMORE CITY HEALTH DEPARTMENT

66 06601

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDDIE M. PEARSON

2. DATE AND HOUR PRONOUNCED DEAD

June 28, 1966

1:10 P.
M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL OR INSTITUTION ADDRESS OF INSTITUTION)

CERTIFICATE AMENDED

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

209 N. Mount Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
SINGLE

8. DATE OF BIRTH

3/5/1923

9. AGE (In years
lost birthday)
43 48If Under 1 Yr. If Under 24 Hrs.
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

GEN CONTRACTOR

11. BIRTHPLACE (State or foreign country)

WINNSBORO S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SAMUEL PEARSON

14. MOTHER'S MAIDEN NAME

LUCENE GATON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWII

16. SOCIAL
SECURITY NO.

218-14-8725

17. INFORMANT

LUCENE GATON 211 N. MOUNT ST

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia, COMPLICATING
DUE TO FRACTURE OF CERVICAL SPINE AND
COMPRESSION OF CORD.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fracture of cervical spine

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 28 66 ?

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

apparently fell

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-29-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-4-66

23C. NAME of CEMETERY or CREMATORY

BALTO NATIONAL

23D. LOCATION

(City, town, or county)

(State)

BALTO MD

24A. DATE REC'D BY HEALTH DEPT.

JUN 30 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Thomas P. Hays 638 N. Gilmor

ADDRESS

Letter dated 8/9/66 from Werner U. Spitz, M.D., Asst. Med. Exam.

CERTIFICATE
VALLEY-FORGE
FACULTY

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GILFORD J BUSH

2. DATE AND HOUR PRONOUNCED DEAD

June 27, 1966

7:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

200 N. Parrish Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

200 N. Parrish Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

4/7/37

9. AGE (In years
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Lawrence Bush

14. MOTHER'S MAIDEN NAME

Pearl

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Jett 1706 Pierce St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Fatty alteration of liver
Partial

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-28-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/2/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

JUN 30 1966

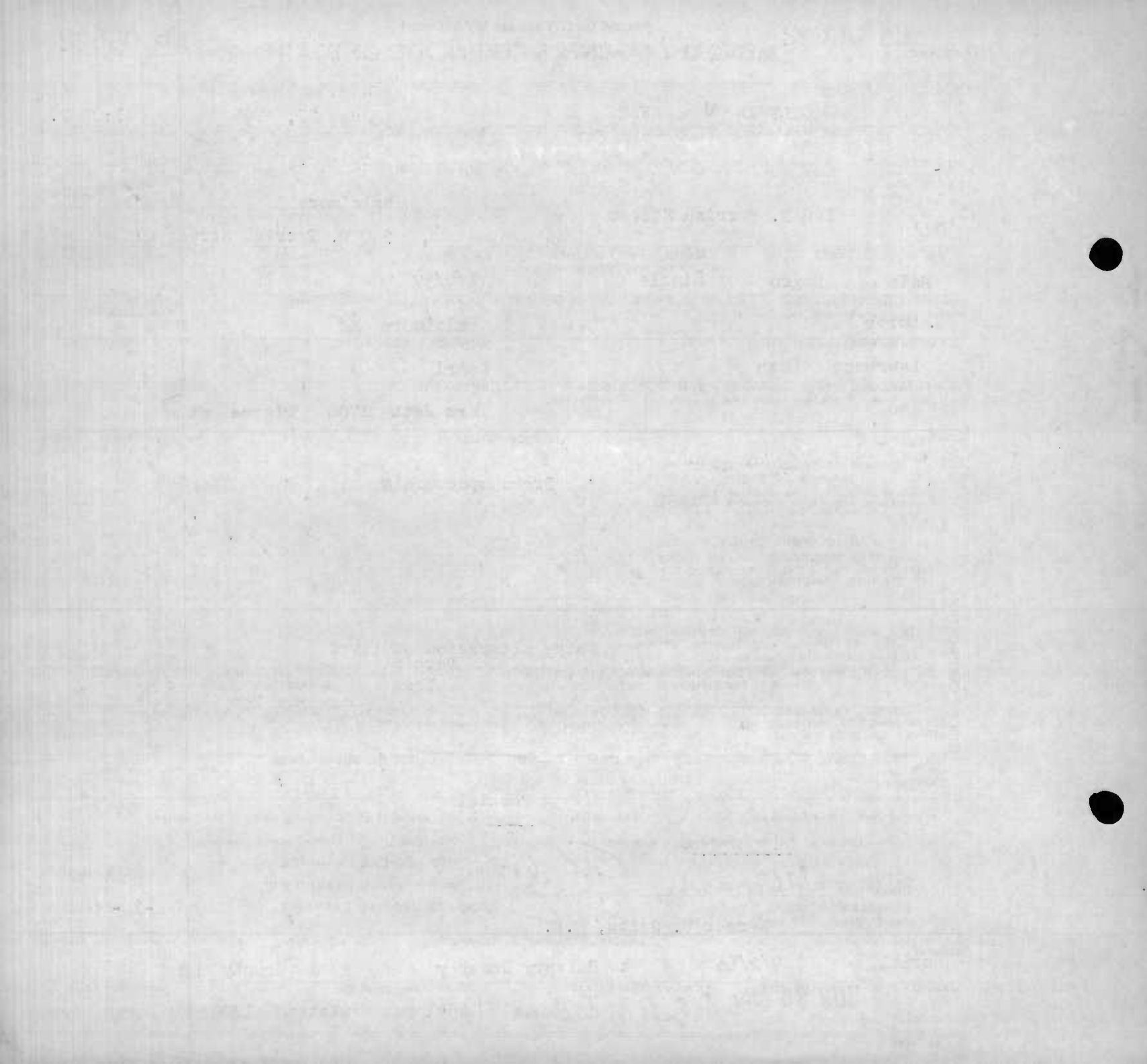
24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave



BIRTH NO. 66 06603		BALTIMORE CITY HEALTH DEPARTMENT		66 06603	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.					
M.E. CASE NO.			2. DATE AND HOUR PRONOUNCED DEAD		
1. NAME OF DECEASED (Type or Print) Thomas M. Ford, Sr.			June 27, 1966 4:00 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL			A. STATE Maryland		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 634 N. Kenwood Avenue		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 9-17-1897	9. AGE (In years last birthday) 68	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME JAMES FORD			14. MOTHER'S MAIDEN NAME FANNIE WALSTON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I		16. SOCIAL SECURITY NO. 216-09-0089	17. INFORMANT ADDRESS Mrs. Helen E. Ford - 634 N. Kenwood Ave.		
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>Arteriosclerotic cardiovascular disease</p> <p>18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>18C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-28-66	
Werner U. Spitz, M.D.					
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 7-1-66		23C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL CEM. BALTO. MD.	
24A. DATE REC'D BY HEALTH DEPT. JUN 30 1966		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR ADDRESS Stanley Miller - 2334 Jefferson St.	

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1927-1928

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FUNERAL DIRECTOR: IMPORTANT

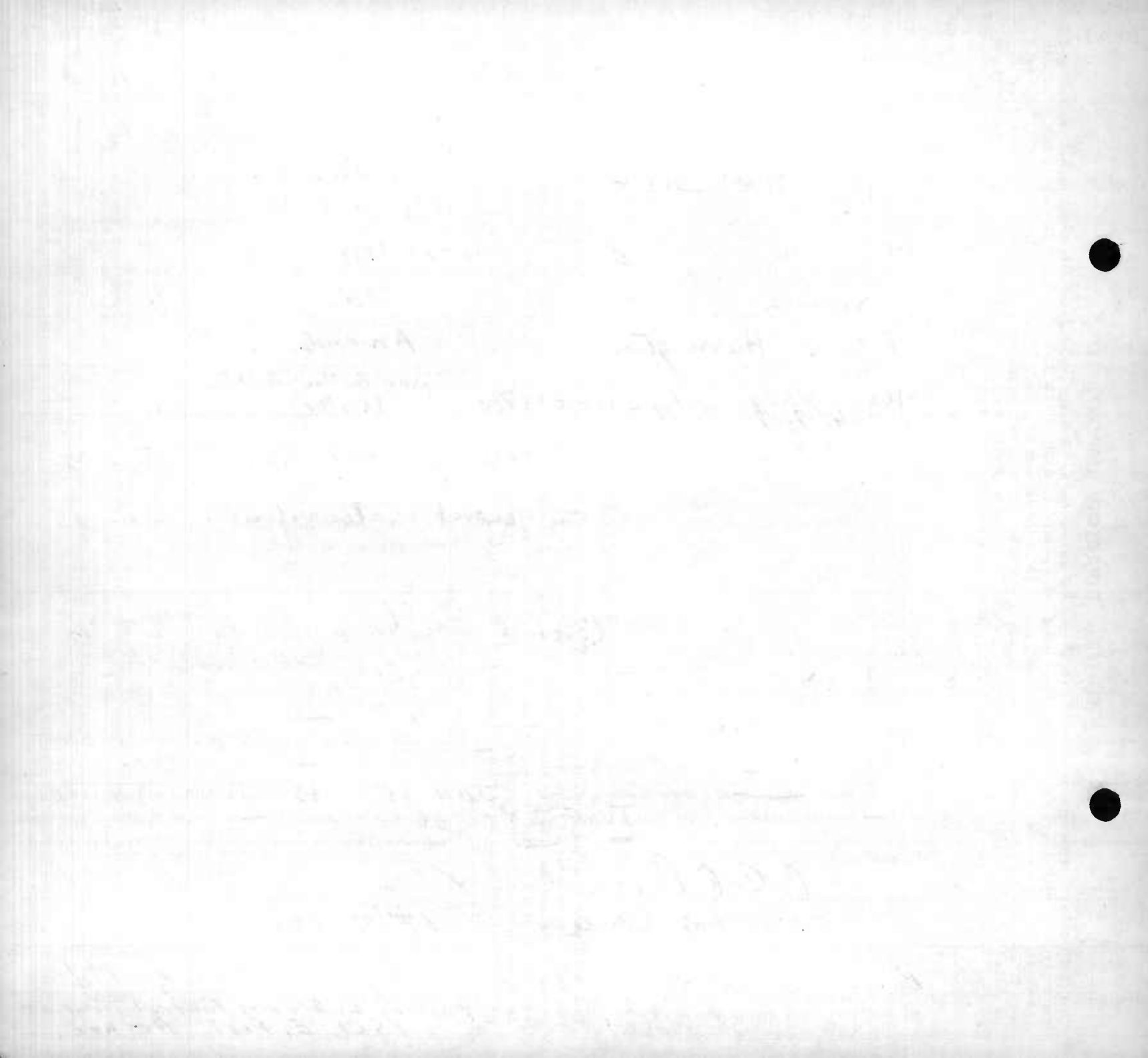
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 06604	
BIRTH NO. 66 06604		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EDWARD MELVIN WRIGHT		2. DATE AND HOUR OF DEATH JUNE 25, 1966 3 ²⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND		B. COUNTY BALTO	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 52-00			
D. STREET ADDRESS (If rural, give location) RT. 14 BOX 11 21220 005							
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 3-8-1896	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH-4940 EASTERN AVENUE BALTO., MD.		ADDRESS 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO H C V D (B) DUE TO CHRONIC RENAL DISEASE (C)		INTERVAL BETWEEN ONSET AND DEATH YES. YRS.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 22 1966 to JUNE 25 1966, that (I) (we) lost saw the deceased alive on JUNE 25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Barry Wayne Uhr M.D.				23B. DATE SIGNED June 25, 1966		23C. PHYSICIAN'S NAME (Type) BARRY WAYNE UHR	
23D. ADDRESS M.D. 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 1/66		24C. NAME of CEMETERY or CREMATORY Bald. Natl Cem.		24D. LOCATION (City, town, or county) (State) 5501 Fredrick Ave	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Milton E. Blukow		25D. ADDRESS 12977 Central St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

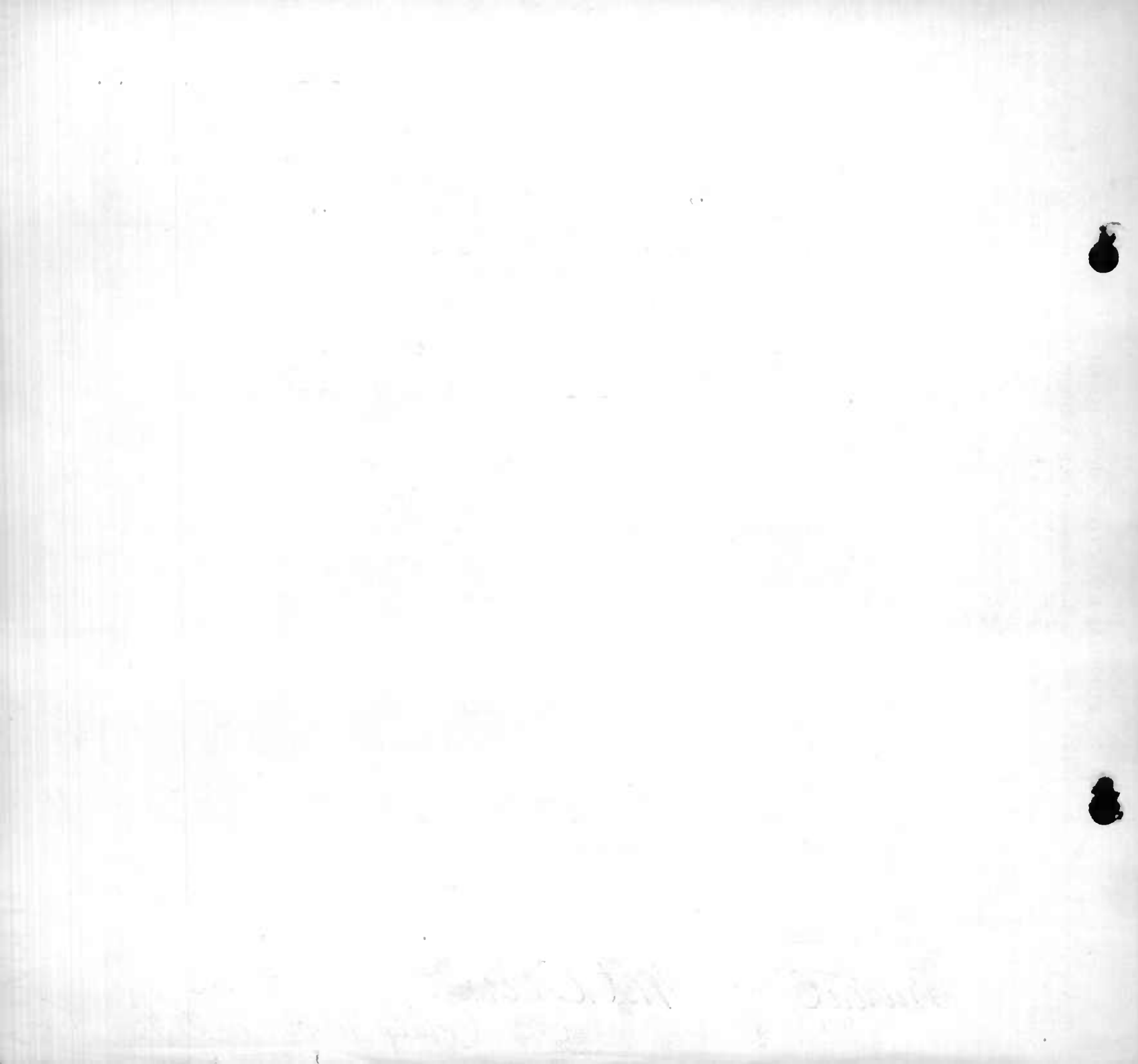
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06605	
BIRTH NO. 66 06605		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FRANK Martin HARRINGTON		2. DATE AND HOUR OF DEATH 6-29-66 11 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1131 Hull Street		A. STATE Md. B. COUNTY 24-01			
5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) S		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		D. STREET ADDRESS (If rural, give location) 1131 Hull St.			
8. DATE OF BIRTH 4-28-1894 9. AGE (In years last birthday) 72		11. BIRTHPLACE (State or foreign country) Md.			
10B. KIND OF BUSINESS OR INDUSTRY -		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Patrick Harrington		14. MOTHER'S MAIDEN NAME Amanda Ryden			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Navy 4/17/15 to 7/8/19		16. SOCIAL SECURITY NO. 213-16-5760		17. INFORMANT Mrs. Bertha AnHitz (sister) ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO general arteriosclerosis		yrs.	
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Cerebral vascular accident		2 1/2 yrs.	
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> -		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from JAN. 15 1963 to JUNE 29 - 1966, that (I) (we) last saw the deceased alive on JUNE 28 - 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE C. Chiu M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-29-66	
23C. PHYSICIAN'S NAME (Type) Chi-Chao Chiu M.D.		23D. ADDRESS 1 E. Randall St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/66		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Charles E. Stevens Funeral Home, Inc. 1501 E. Fort Avenue			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06606	
BIRTH NO. 66 06606		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Annie K. Moriarty		2. DATE AND HOUR OF DEATH 6-28-66 8:00 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) altimore	
FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters of the Poor 1200 Valley St. Baltimore Md 21202		D. STREET ADDRESS (If rural, give location) 1200 Valley St.,		16-01	
5. SEX F	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 10-22-1876	9. AGE (In years last birthday) 89	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dramatics		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ghent Belgium	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Matthew Moriarty		14. MOTHER'S MAIDEN NAME Annie Colbert	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-34-7558		17. INFORMANT ADDRESS Little Sisters of the Poor	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Coronary occlusion		CAUSE OF DEATH (A) DUE TO Coronary occlusion (B) DUE TO Congestive heart failure (C) DUE TO Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 to 6-27 1966 , that (I) (we) last saw the deceased alive on 6-27 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Ankudas		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-28-66	
23C. PHYSICIAN'S NAME (Type) Stanley Ankudas		23D. ADDRESS M.D. 1802 W. Baltimore St.,			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Buried June 27/66		June 27/66		Mt. Olivet	
24D. LOCATION (City, town, or county) (State)		Baltimore			
25A. DATE OF HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 30 1966		Robert E. Fink		Philip Herwig Sons	
ADDRESS		2024			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06607		REGISTERED NO. 66 06607	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) A. Sadie Heath				2. DATE AND HOUR OF DEATH June 29, 1966 9:55 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ardleigh Nursing Home 2095 Rockrose Avenue Baltimore, Maryland 11				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4 South Gay St. 21202			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 11/14/1884	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mission Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alfred Albert Heath				14. MOTHER'S MAIDEN NAME Alice Sangter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Miss Jane L. Light 4 South Gay St. Grace and Hope Mission			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 44-3X I Hypertensive Cardiovascular Disease				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 6/29/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 14 1960 to June 29 1966 , that (I) (we) last saw the deceased alive on June 22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. Grafton Hersperger M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/29/66	
23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger M.D.				23D. ADDRESS 214 Medical Arts Building			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/1966		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Wm. J. Tipton & Sons		ADDRESS Baltimore, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 06608	
BIRTH NO. 66 06608											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) HOWARD LOUIS LAMBERT						2. DATE AND HOUR OF DEATH 6-29-66 3 PM M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE M.D. B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL						C. CITY OR TOWN (If outside city limits, write RURAL and give township) 2 W. UNIV. PKWAY 12-01					
						D. STREET ADDRESS (If rural, give location) BALTO.					
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH 08-18-89		9. AGE (In years last birthday) 76		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY Architectural engineer M.D.				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LOUIS ALBERT LAMBERT						14. MOTHER'S MAIDEN NAME ELLEN VAUGHAN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I				16. SOCIAL SECURITY NO. 216-14-0867		17. INFORMANT Mrs. Hildreth Lambert WIFE				ADDRESS S.A.A.	
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)						(A) BRAIN DAMAGE DUE TO				15 YRS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) CARCINOMA OF SCALP DUE TO				15 YRS	
						(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. C.V.A. SJL											
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-7 1966 to 6-29 1966, that (I) (we) lost saw the deceased alive on 6-29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Arthur M. LaBruce Jr.						M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-28-66			
23C. PHYSICIAN'S NAME (Type) ARTHUR M. LA BRUCE, JR. M.D.						23D. ADDRESS UNION MEMORIAL HOSP.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/1966		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery				24D. LOCATION (City, town, or county) (State) Pikesville, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR Wm. J. Fickner & Sons with 24A.			
ADDRESS Balt., Md.											



08-13-84

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CAUTION OF 24th

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Section M. Johnson

CAUTION MEMORANDUM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 06609	
BIRTH NO.				66 06609	
M.E. CASE NO.				66 06609	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Jesse Weeds Garnett				6/28/66 10:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
38 University Hospital				Md Baltimore	
5. SEX F 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				D. STREET ADDRESS (If rural, give location)	
Laundress				528 N. Calhoun ST.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
?		Kate Garnett		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Niece	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				Carcinomatosis	
ANTECEDENT CAUSES				? Endometrial Ca	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO	
II				(C) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
6/14/66		Node Biopsy - Supracard		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
—		—		—	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
—		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		—	
22. I certify that (I) (this hospital) attended the deceased from 6/19/66 to 6/25/66 that (I) (we) last saw the deceased alive on 6/25/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
B. Ann Ward				6/25/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
B. Ann Ward				—	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7/2/66		Mt Auburn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
—		Robert E. Farkema		Stetson D. Wilson 523 N. Calhoun St.	
JUN 30 1966					

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Baltimore
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FUNERAL DIRECTOR: IMPORTANT

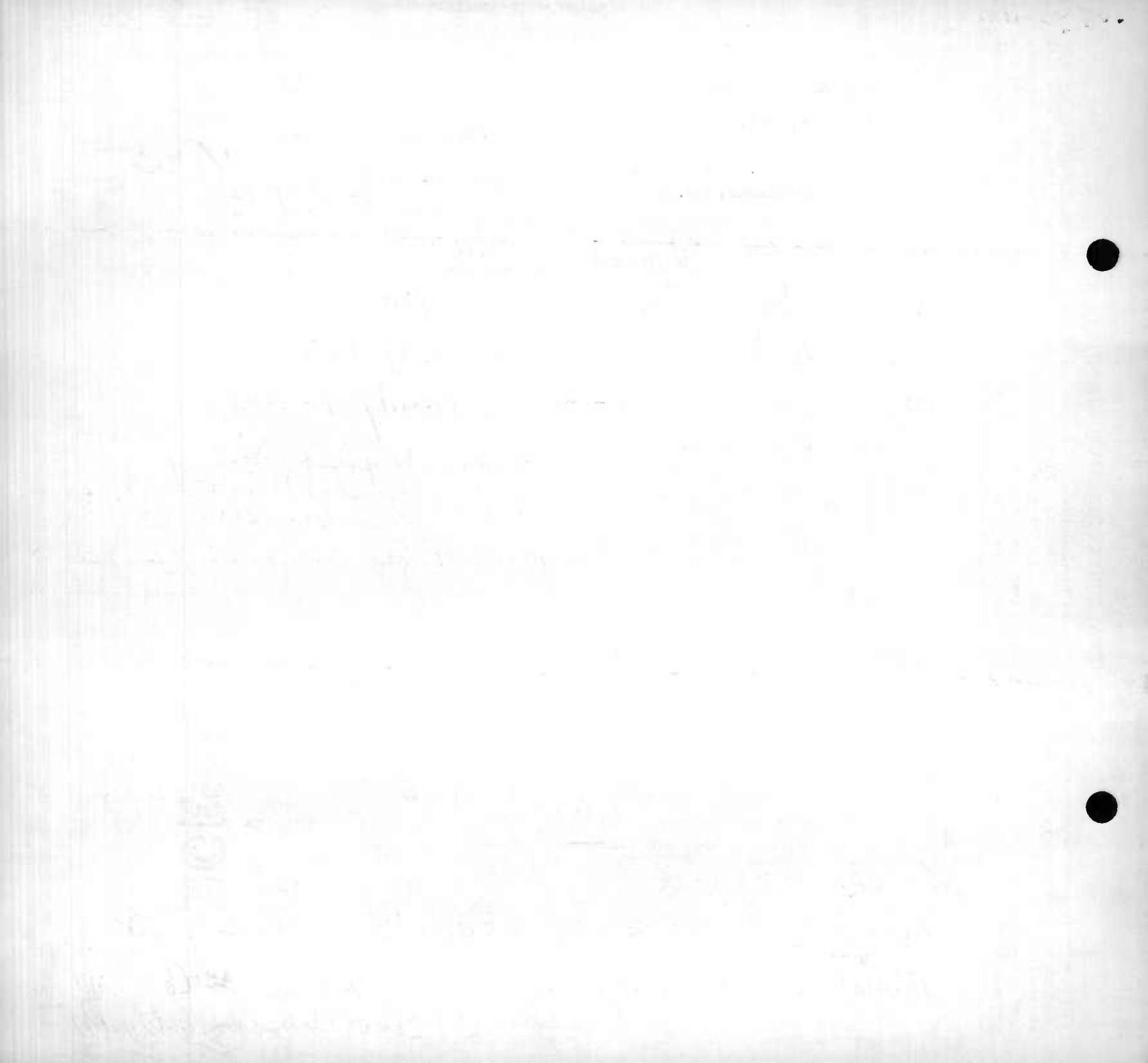
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06610		BALTIMORE CITY HEALTH DEPARTMENT SUNDAY MAY 74 11/18 AM NONE 09-10-66	
M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CHANEY, FRANCIS CARROLTON		2. DATE AND HOUR OF DEATH 6-29-66 11-45 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Balto	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00	
5. SEX Male		6. RACE wh	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) wid.		8. DATE OF BIRTH 09-10-91 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Nathan Choney		14. MOTHER'S MAIDEN NAME Prudence CAVY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-8044	
17. INFORMANT Hosp Records		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) cardiac arrest (B) Emphysema congestive (C) heart failure	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none	
20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-24 19 66 to 6-29 19 66, that (I) (we) last saw the deceased alive on 6-29 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE B H Gross		23B. DATE SIGNED 6-29-66	
23C. PHYSICIAN'S NAME (Type) B H. GROSS		23D. ADDRESS M.D. UNION MEMORIAL HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-66	
24C. NAME OF CEMETERY or CREMATORY GREENWOOD CEM		24D. LOCATION (City, town, or county) (State) Orlando Fla.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR EVANS + Patty Hill & Harford		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

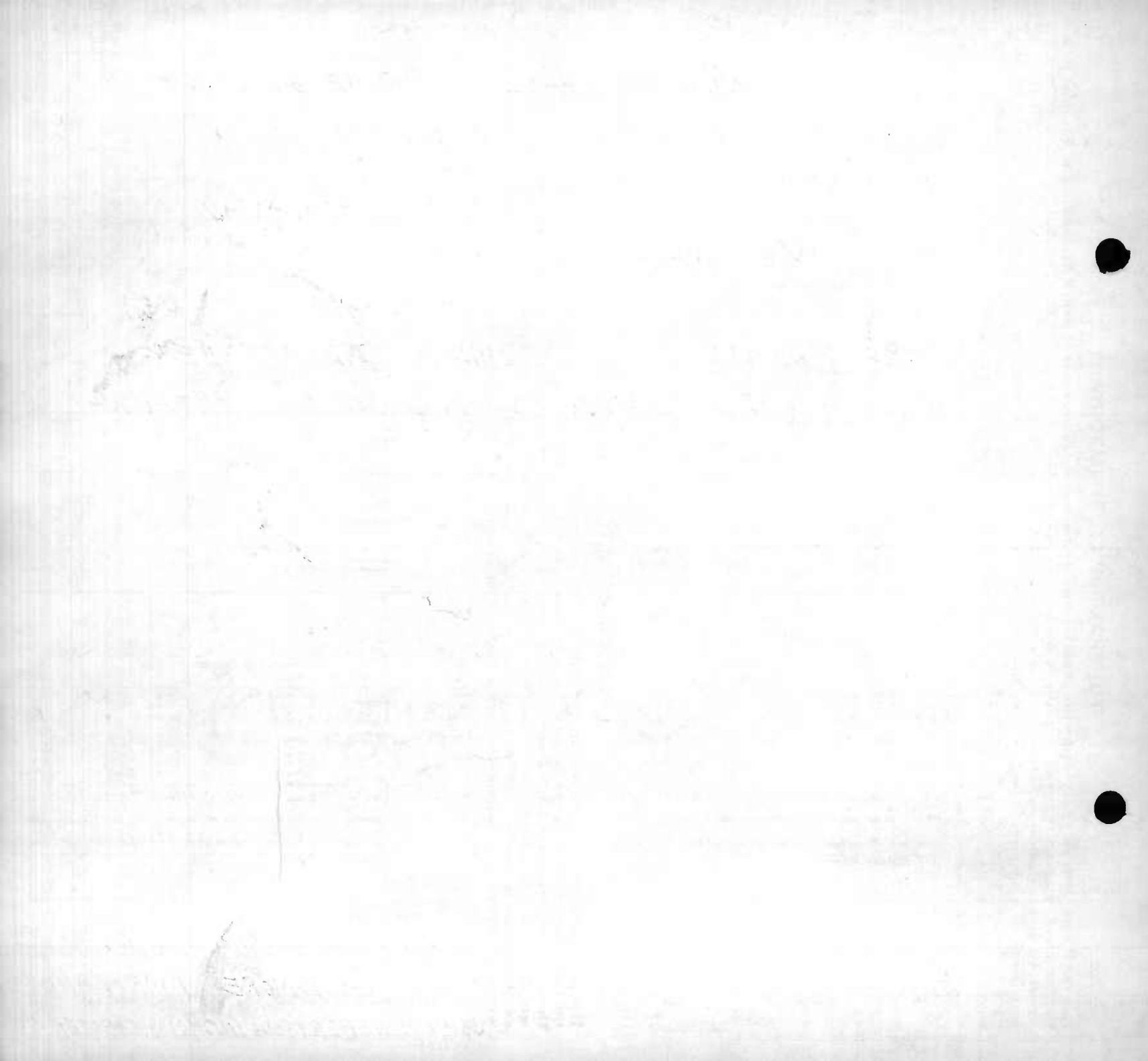
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06611		CERTIFICATE OF DEATH		Registered No. 66 06611	
1. NAME OF DECEASED (Type or Print) <i>Charles Clark</i>				2. DATE AND HOUR OF DEATH <i>6/26/66</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Midtown Home, Inc.</i> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>808 St. Paul Street Baltimore, Md.</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balti</i> <i>11-02</i> D. STREET ADDRESS (If rural, give location) <i>808 St. Paul St</i>					
5. SEX <i>Male</i>	6. RACE <i>Caucasian</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWER</i>	8. DATE OF BIRTH <i>2/11/90</i>	9. AGE (In years last birthday) <i>76</i>	11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY?		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>VEG. DEALER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Food</i>		13. FATHER'S NAME <i>Wm Clark</i>			14. MOTHER'S MAIDEN NAME <i>MARY PETERSON</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>215-16-2535</i>		17. INFORMANT <i>Family Records</i>			ADDRESS		
18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Cardio Respiratory Failure</i> DUE TO <i>A. Myocardial Infarction</i> (B) <i>Arteriosclerosis CVD</i> DUE TO (C) <i>Mid Thigh Amputation (Recent)</i>				INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION <i>6/26/66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>6/11/66</i> 19 to <i>6/26/66</i> 19, that (I) (we) lost saw the deceased alive on <i>6/26/66</i> 19 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.									
23A. SIGNATURE <i>William Appleford</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>William Appleford</i>				23D. ADDRESS <i>5401 Park Heights Rd.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-28-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Waucho Chapel</i>		24D. LOCATION (City, town or county) (State) <i>Balti Co. MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>C. F. Evans, Jr</i> ADDRESS <i>8862 Nantux Rd</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

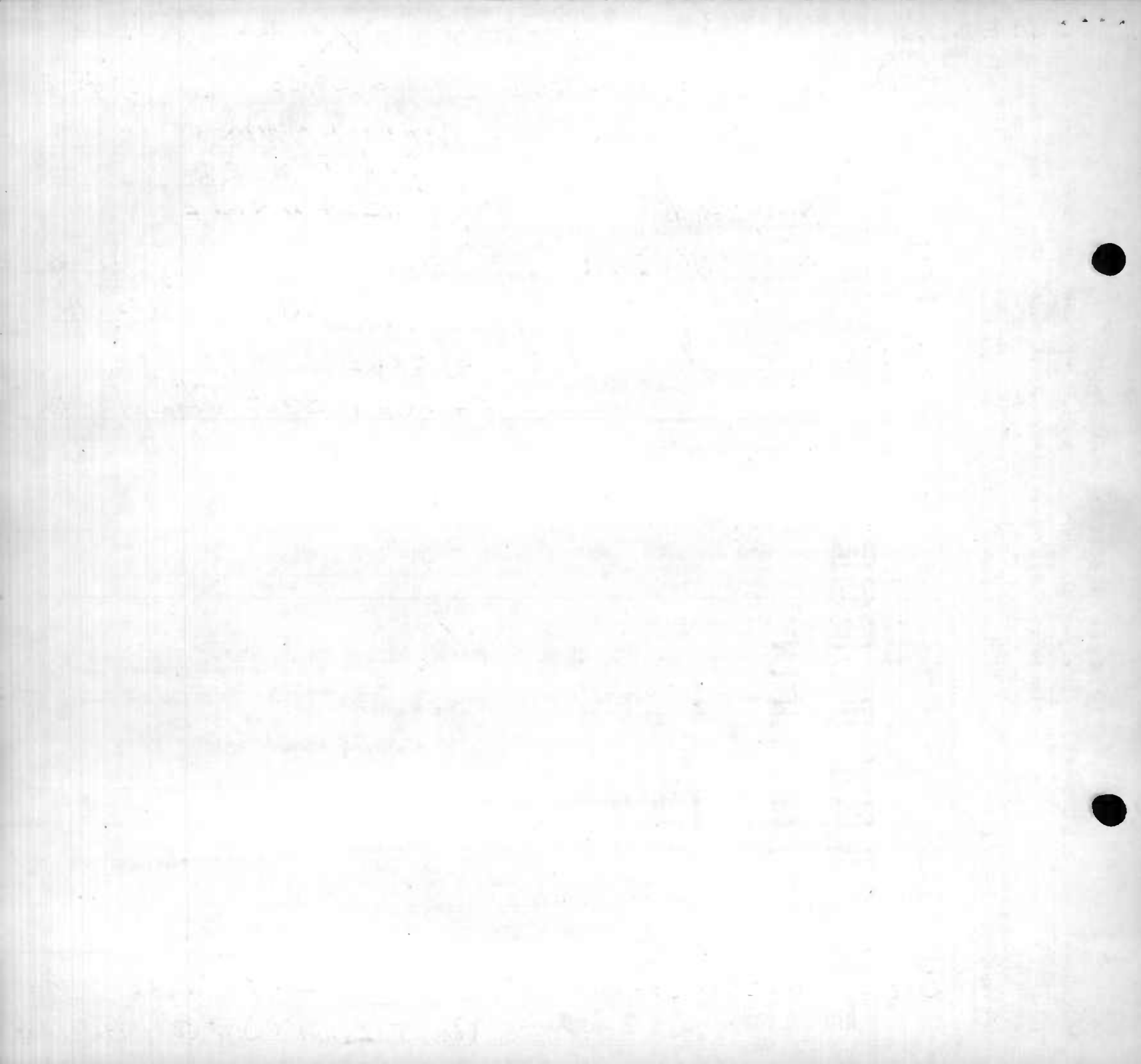
BIRTH NO. 66 06612				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06612	
1. NAME OF DECEASED (Type or Print) ERNEST WILLIAM BAASE				2. DATE AND HOUR OF DEATH JUNE 28, 1966 9:45 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL				A. STATE MARYLAND		B. COUNTY BALTIMORE			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 122 S. BROADWAY			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 8-2-1923	9. AGE (In years last birthday) 43	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CARL BAASE				14. MOTHER'S MAIDEN NAME META DIECHGRABER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII				16. SOCIAL SECURITY NO. 217-12-3346		17. INFORMANT WANDA BAASE 122 S. BROADWAY			
18. 4-20-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) DUE TO Arteriosclerotic cardiovascular disease		(C) Long standing disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 6/30/66			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from as patient at Cardiac Clinic Johns Hopkins Hospital that (I) (we) last saw the deceased alive on June 10, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Walter R. Welzant M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 6/30/66			
23C. PHYSICIAN'S NAME (Type) WALTER R. WELZANT M.D.						23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-1-66		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS JOHN M WEBERTSONS INC. 401 S. CHESTER ST					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 06613 4				
BIRTH NO. 66-13045 66 06613									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Denise Beth Woolford					2. DATE AND HOUR OF DEATH 6/27/66 12:45 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSP. of MARYLAND					A. STATE MARYLAND				
					B. COUNTY Balto				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00					D. STREET ADDRESS (If rural, give location) 3419 GLENVIEW DR.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 6/26/66	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Arthur J. Woolford Jr.					14. MOTHER'S MAIDEN NAME Cheryl McAllen				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Father - 3419 Glenview Dr.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 776X I PREMATURITY					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 6-26 to 6-27 and that (I) (we) lost saw the deceased alive on 6-27 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Marcia Evangelista					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6-27-66	
23C. PHYSICIAN'S NAME (Type) MARCIA EVANGELISTA					23D. ADDRESS Lutheran Hospital				
24A. BURIAL, CREMATION, REMOVAL (Specify) DORIAL		24B. DATE 6-29/66		24C. NAME OF CEMETERY or CREMATORY Garden of Peace		24D. LOCATION BALTIMORE MD		(State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966		25B. NAME OF REGISTRAR Robert E. Farber			25C. FUNERAL DIRECTOR Chas. F. Evans & Son 8802 Howard Rd.				



46-54-98
DH
B436
M320

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06614		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06614	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BLYTHER, Lucretia (Matthews)		2. DATE AND HOUR OF DEATH 6-29-66		120A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md.		A. STATE Maryland		B. COUNTY 16-06	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 904 Ashburton St. #21216 007			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) ?	8. DATE OF BIRTH 4-18-23	9. AGE (In years last birthday) 43	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joshua Blyther		14. MOTHER'S MAIDEN NAME Bertha Adams	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Baltimore, Md. #21224 RECORDS: BCH-4940 Eastern Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO UTL c Sepsis CVA's (B) DUE TO ASCVD (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days 4 hrs 2 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-26 19 66 to 6-29 19 66, that (I) (we) last saw the deceased alive on 6-29 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alex Silverman M.D.		23B. DATE SIGNED 6-29-66			
23C. PHYSICIAN'S NAME (Type) Alex Silverman		23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-66		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cml	
24D. LOCATION Balto Md		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR Choy O. Wilson		25D. ADDRESS 1000 Brantley Rd			

Reference for [illegible]

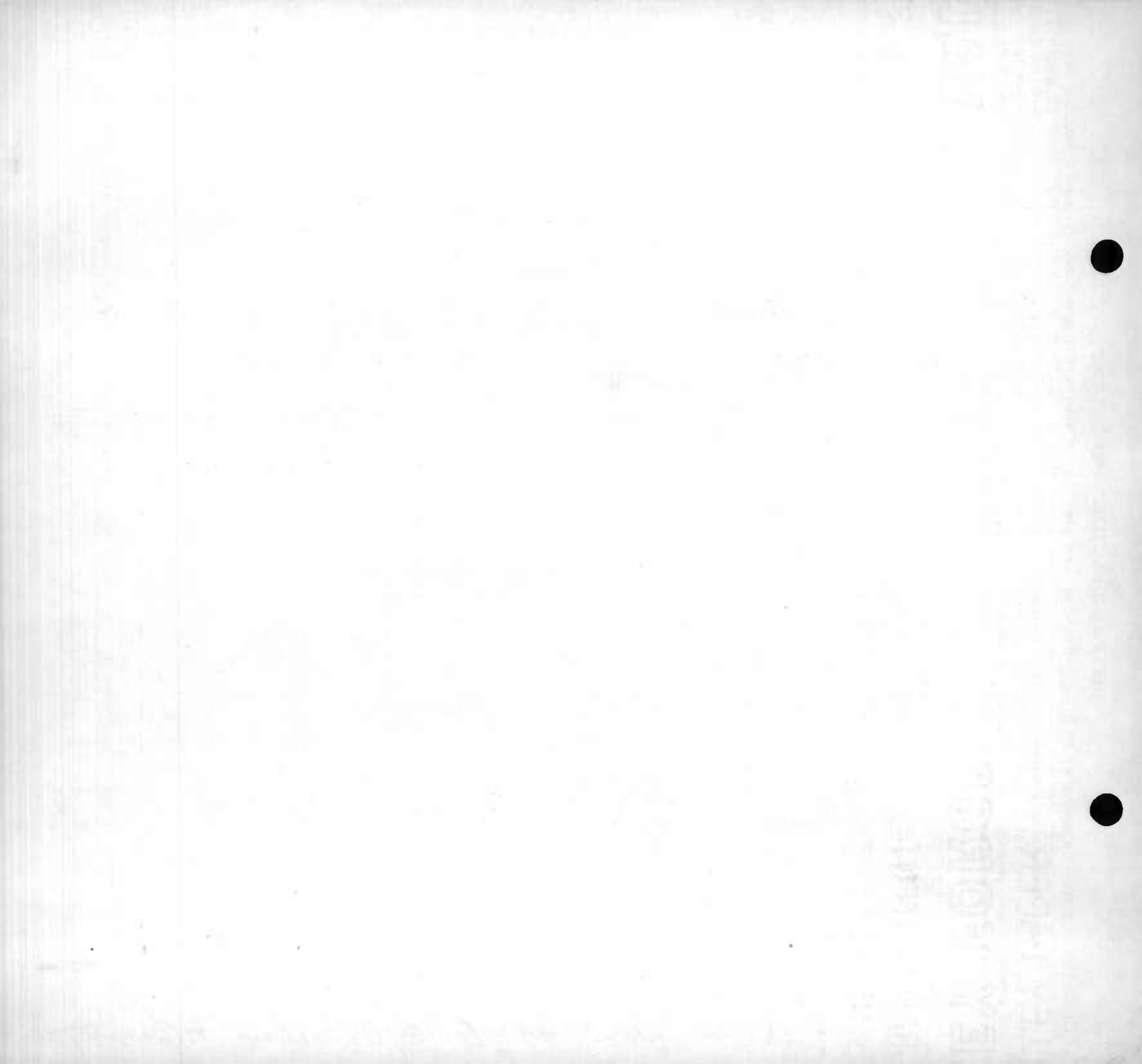
11/15/20
CVA's
HACND

11/15/20
CVA's
HACND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06615		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06615	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type of Person) <i>Robert Lillian</i>		2. DATE AND HOUR OF DEATH <i>6/27/66</i> <i>3:00</i> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 Johns Hopkins Hosp</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore Md</i>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If not, give location) <i>1849 W. Fayette St</i>			
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>6/1/04</i>	9. AGE in years (lost birthday) <i>62</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Frank Streams</i>		14. MOTHER'S MAIDEN NAME <i>Helena Holly</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Margaret Jegeri</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>422.1 I</i>		CAUSE OF DEATH <i>Intra cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <i>ASCVD</i>		(B) DUE TO <i>gys</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/15</i> 19 <i>66</i> to <i>6/27</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>3:13 am 6/27</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Barry J. Zacherle</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/27/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Barry J. Zacherle</i>		23D. ADDRESS M.D. <i>550 N Broadway, Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-1-66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Int Arden Court</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Choy O. Wilson</i>	
25D. ADDRESS <i>1001 Brantley Dr</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06616		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06616	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SCHAEFER, LILLIAN REED		2. DATE AND HOUR OF DEATH June 29 '66 8:45 am M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-14			
		D. STREET ADDRESS (If rural, give location) 4643 Schenley Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/28/85	9. AGE (in years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - HOUSEWIFE HOME		10B. KIND OF BUSINESS OR INDUSTRY OWN		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Reid		14. MOTHER'S MAIDEN NAME FRANKLIN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-03-5684-B		17. INFORMANT ROLAND E. SCHAEFER (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4-20-11		CAUSE OF DEATH Myocardial infarction Ruptured myocardium		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Hemopericardium, 300cc.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. TM					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 27 19 66 to June 29 19 66, that (I) (we) last saw the deceased alive on June 29 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE W. H. Tsung		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 29 '66	
23C. PHYSICIAN'S NAME (Type) WEN-HAN TSUNG		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-1966		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville, Md.		24E. STATE (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966		25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md.	

Lincoln Memorial Hospital
Female White married
10/28/82 80

William Reid
Lincoln

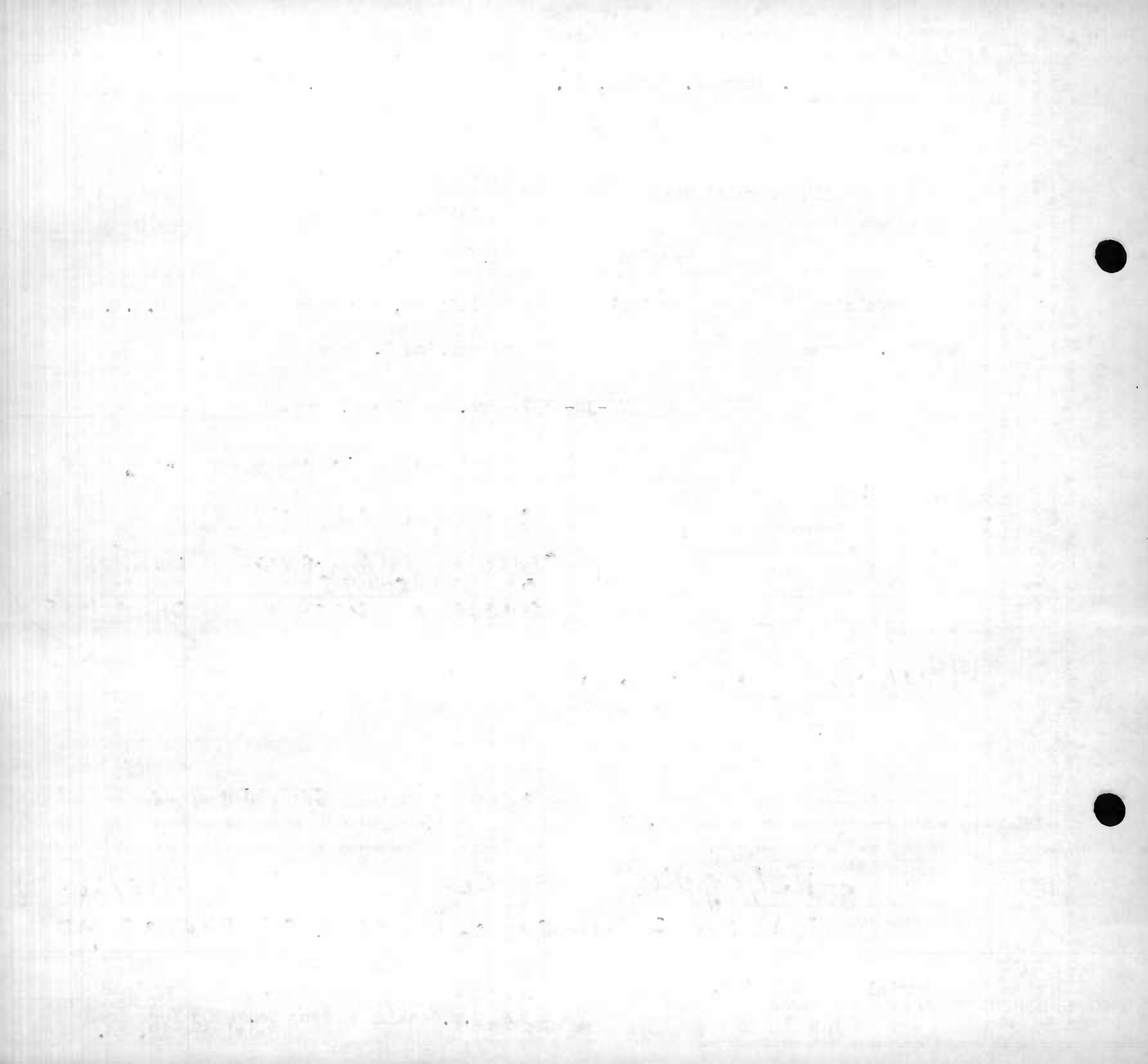
100-200-11

NEW-HAN TSHAD
100-200-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06617				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06617	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Dr. Henry M. Thomas, Jr.				2. DATE AND HOUR OF DEATH June 28, 1966 2:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 314 Overhill Road				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 314 Overhill Road			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/30/1891	9. AGE (in years lost birthday) 74	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10B. KIND OF BUSINESS OR INDUSTRY Medical		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry M. Thomas				14. MOTHER'S MAIDEN NAME Josephine G. Carey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI and WWII		16. SOCIAL SECURITY NO. 579-38-0737		17. INFORMANT Mrs. Caroline B. Thomas		ADDRESS (Same)	
18. 153.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARCINOMA COLON WITH METASTASIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CEREBRAL HEMMORHAGE OR METASTASES DUODENAL ULCER				CAUSE OF DEATH (A) CARCINOMA COLON WITH METASTASIS (B) GENERAL METASTASIS (C) CEREBRAL HEMMORHAGE OR METASTASES DUODENAL ULCER		INTERVAL BETWEEN ONSET AND DEATH Oct. 1965 JUNE 28 66 DEC 9, 1965	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 10/20/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MAY 29 1966 to JUNE 28 1966 , that (I) (we) last saw the deceased alive on JUNE 28 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ralph G. Hills				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/28/66	
23C. PHYSICIAN'S NAME (Type) RALPH G. HILLS M.D.				23D. ADDRESS 18 E EAGER ST. BALTO 2 MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/1966		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966		25B. NAME OF REGISTRAR Robert E. Jenkins, MD		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.			

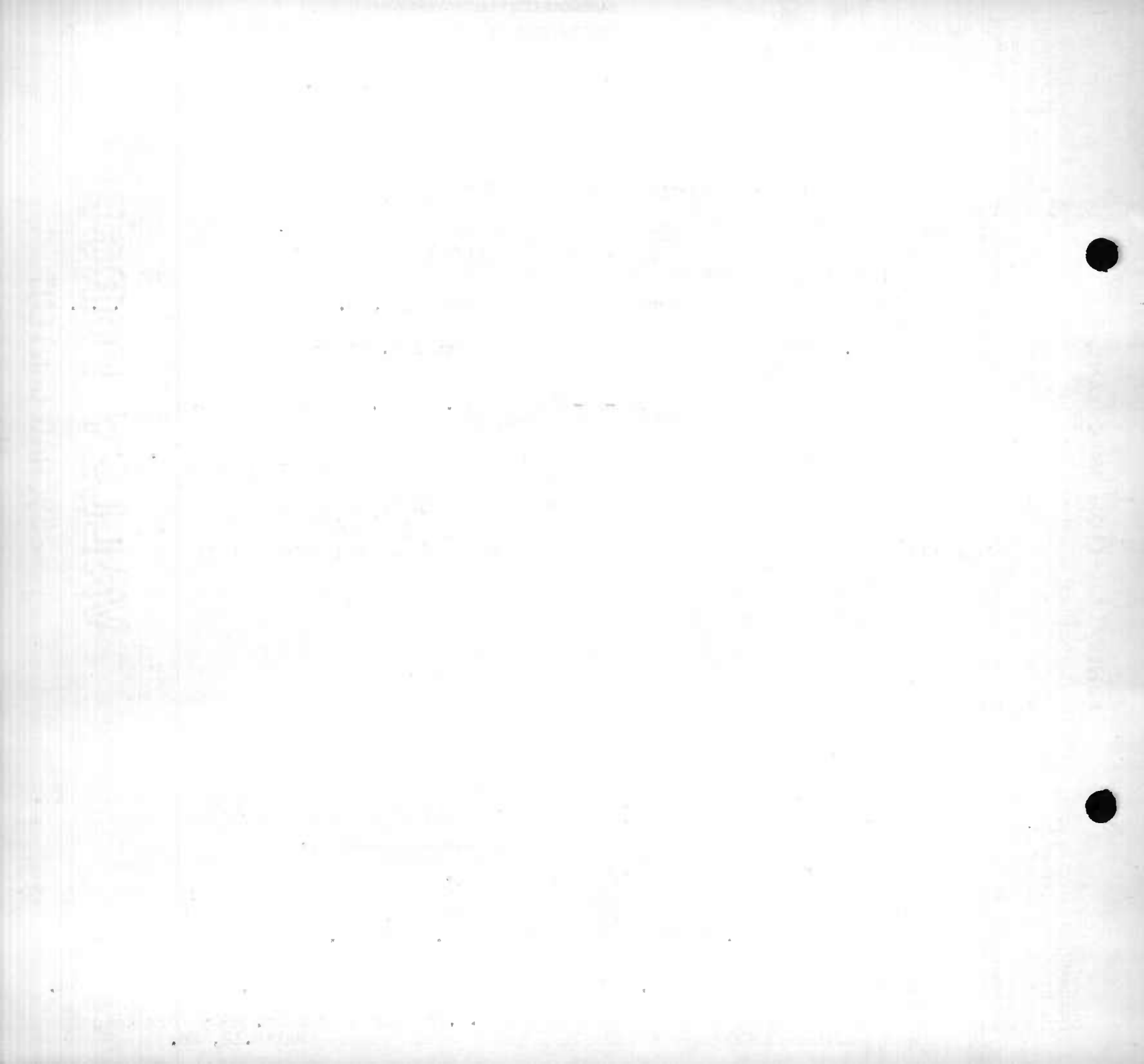


VALLEY FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06619</u>	
BIRTH NO. <u>66 06619</u>		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH <u>June 29, 1966</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Orra Janney Turner</u>		2. DATE AND HOUR OF DEATH <u>June 29, 1966</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		M. <u>12-01</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Hillcrest Nursing Home</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		D. STREET ADDRESS (If rural, give location) <u>4014 Linkwood Road</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>11/7/1 876</u>	9. AGE (In years lost birthday) <u>89</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas M. Turner</u>		14. MOTHER'S MAIDEN NAME <u>Rachel B. Janney</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-46-0258</u>		17. INFORMANT ADDRESS <u>Mrs. John M. Brooks (Same)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>720.21</u> <u>Arterio-sclerosis Hypertension 30 years</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Coronary Hypertrophy Angina 20 years</u>		(B) <u>Pectoral Cerebral Hemorrhage 3 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1945</u> to <u>June 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>JUNE 29 (3 PM) 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>NO</u>					
23A. SIGNATURE <u>Ralph G. Hills</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>June 30 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ralph G. Hills</u>		23D. ADDRESS M.D. <u>18 E. Eager St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet</u>	
24D. LOCATION <u>Frederick,</u>		(City, town, or county)		(State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1966</u>		25B. NAME OF REGISTRAR <u>R. E. Jenkins</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

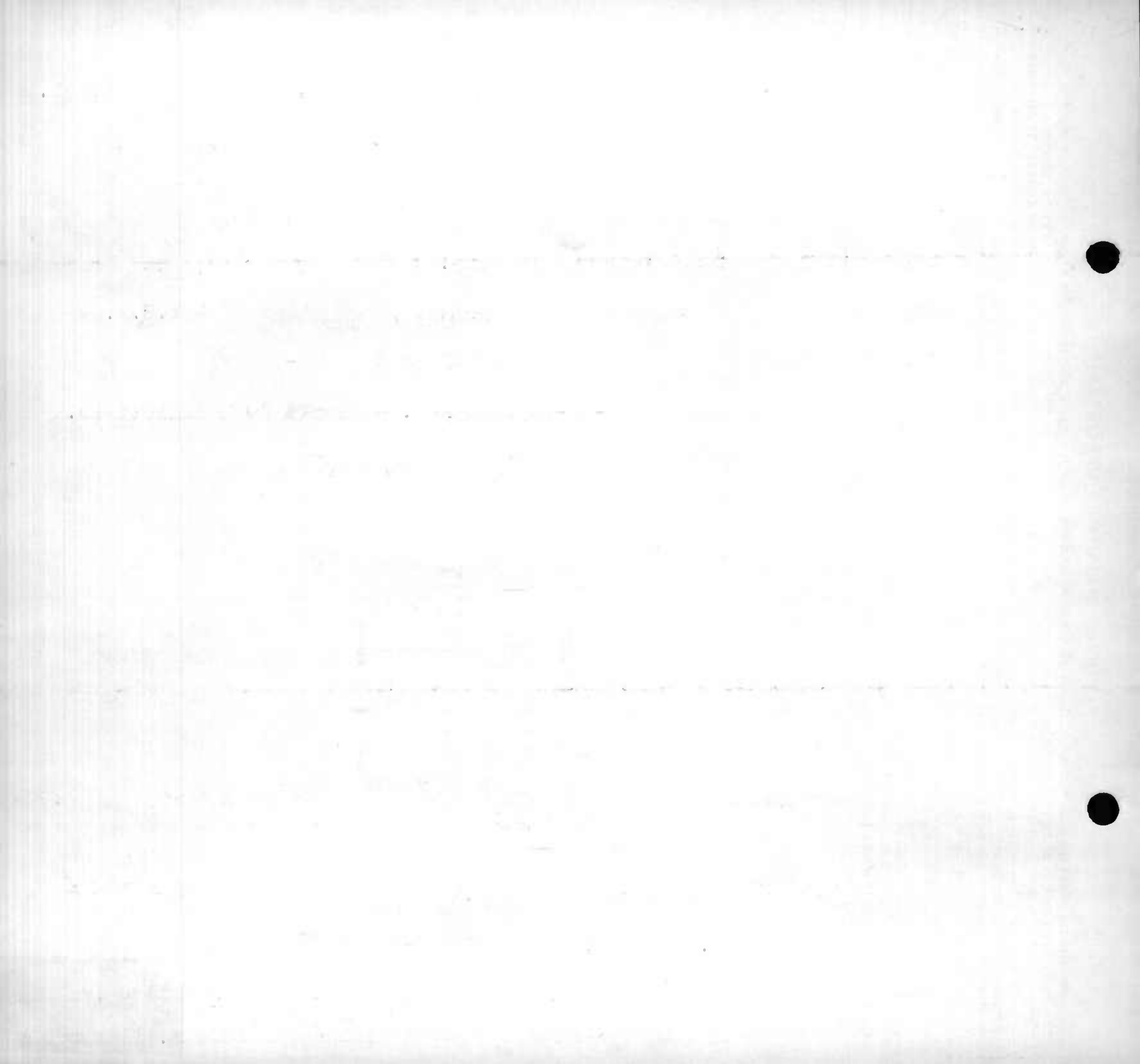
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06620	
BIRTH NO.				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <i>Frances Heaps Wallace</i>			2. DATE AND HOUR OF DEATH <i>6-29 1966 2:48 PM</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution/ residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>			A. STATE <i>Maryland</i>		
(If not in hospital or institution, give street address or location)			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>5911 Yorkwood Rd.</i>		
5. SEX <i>F.</i>	6. RACE <i>W.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>01-30-07</i>	9. AGE (In years last birthday) <i>59</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Education</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia Maryland</i>	
13. FATHER'S NAME <i>Unknown W. Henry Heaps</i>			14. MOTHER'S MAIDEN NAME <i>Unknown Marion Scarborough</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-22-8049</i>		17. INFORMANT <i>Robert A. Wall</i> ADDRESS <i>5911 Yorkwood Rd. Baltimore Md. 21212</i>	
18. <i>502.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			(A) <i>Cerebral anoxia</i>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>Cor-pulmonale with congestive heart failure 7 months</i>		
II			(C) <i>acute & chronic bronchitis pulmonary emphysema 2-3 years</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-27 1966</i> to <i>6-29 1966</i> that (I) (we) last saw the deceased alive on <i>6-29 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sh. S. W. / S. J.</i>				23B. DATE SIGNED <i>6-29 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>SPEN SPO TSENG</i>				23D. ADDRESS <i>Union Memorial Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/1/1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Moreland Memorial Park</i>	
				24D. LOCATION (City, town, or county) (State) <i>Parkville, Balto. Co., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06621		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06621	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Frank L. Siminski		2. DATE AND HOUR OF DEATH June 28, 1966 6:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1-01		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 3021 Elliott Street		D. STREET ADDRESS (If rural, give location) 3021 Elliott Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 6 1885	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Long Shoreman		10B. KIND OF BUSINESS OR INDUSTRY Shipping		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Matthew Siminski		14. MOTHER'S MAIDEN NAME Mary Anne	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-6652		17. INFORMANT John W. Siminski 3021 Elliott St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cr. of throat (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 19 66 to 6/28 19 66, that (I) (we) last saw the deceased alive on 6/27/66 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph R. Liberto		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/29/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Joseph R. Liberto, M.D. 3508 Bank Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/66		24C. NAME of CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966		25B. NAME OF REGISTRAR Robert E. Fairley, M.D.	
25C. FUNERAL DIRECTOR Marie Fialkowski		25D. ADDRESS 1000 S. Kenwood Av			



For Approval by Medical Examiner
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Baltimore City Health Department		Baltimore City Health Department	
BIRTH NO. 66 06622				CERTIFICATE OF DEATH		Registered No. 66 06622	
1. NAME OF DECEASED (Type or Print) HERMAN DEITCH				2. DATE AND HOUR OF DEATH June 29, 1966 10:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE PENNSYLVANIA B. COUNTY V-35			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33				C. CITY OR TOWN (If outside city limits, write RURAL and give township) HARRISBURG			
				D. STREET ADDRESS (If rural, give location) 2612 N. 3RD STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-25-96	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY SHOE		11. BIRTHPLACE (State or foreign country) LITUA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORRIS DEITCH				14. MOTHER'S MAIDEN NAME ADA T.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 198-28-619			
17. INFORMANT IRVING M. DELTECH HARRISBURG, 3503 N. FOURTH ST. PENNA				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 19A. DATE OF OPERATION June 29, 1966 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured aneurysm 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (this hospital) attended the deceased from 6/23 1966 to 6/29 1966, that (we) last saw the deceased alive on 6/29 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death. 23A. SIGNATURE H.L. GERTNER 23B. DATE SIGNED 6/29/66 23C. PHYSICIAN'S NAME (Type) H.L. GERTNER 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 7-1-66 24C. NAME of CEMETERY or CREMATORY BETH EL CEMETERY 24D. LOCATION (City, town, or county) (State) HARRISBURG, PENNA. 25A. DATE RECEIVED BY HEALTH DEPT. JUN 30 1966 25B. NAME OF REGISTRAR Robert E. Taylor 25C. FUNERAL DIRECTOR Wm Cook - Brooks Townson 25D. ADDRESS 1030 York Rd. Towson, Md.							

Signature of person
mountain oil company

ASCVD

butte co.

June 28, 1966 Rpt. on sample

W. L. Butler, Jr.

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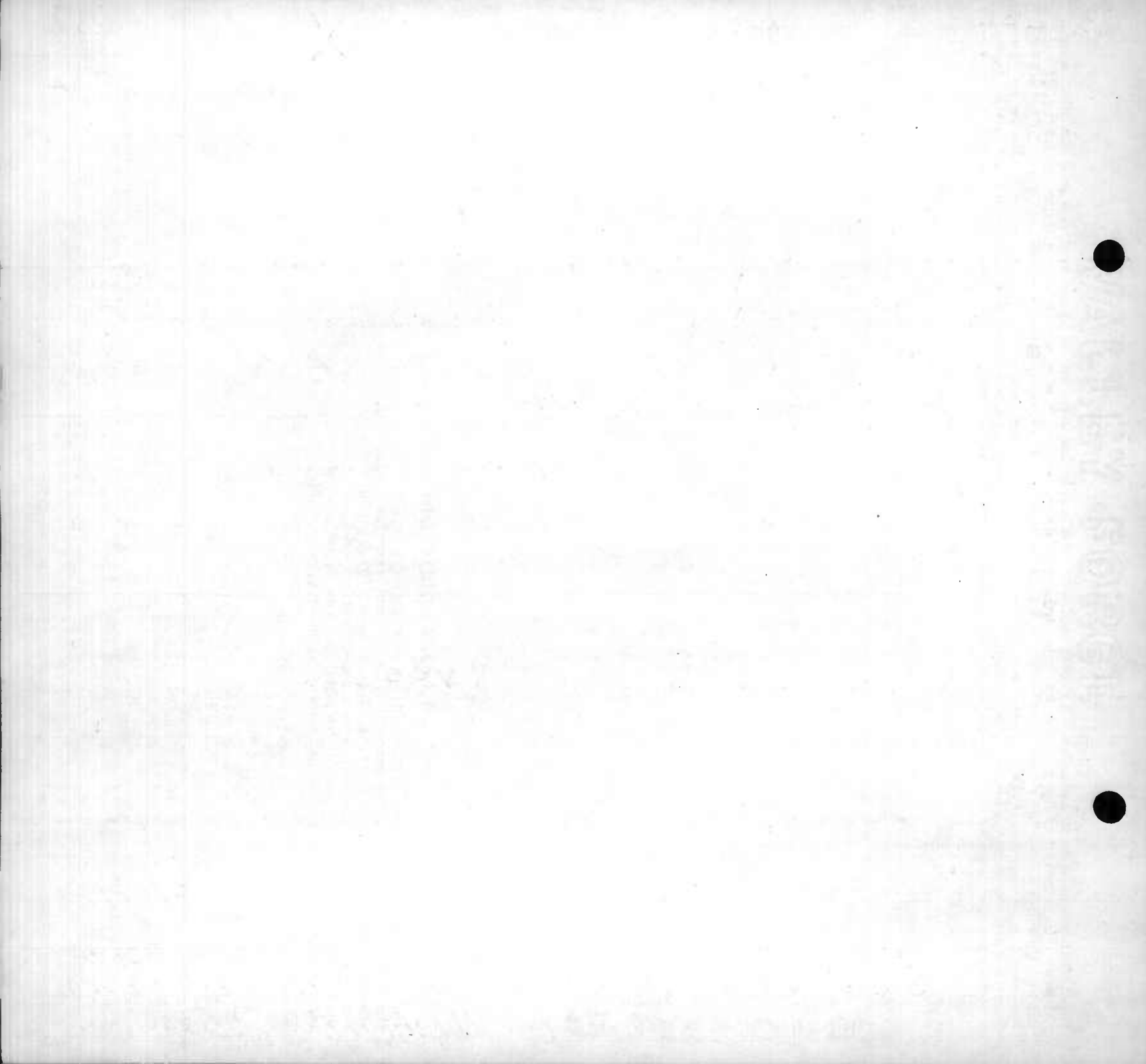
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06623</u>	
BIRTH NO. <u>66 06623</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Browne, Van Murray</u>		2. DATE AND HOUR OF DEATH <u>6/20/66</u> <u>3:40</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Delaware</u> B. COUNTY <u>V-07</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Selbyville</u>			
		D. STREET ADDRESS (If rural, give location) <u>P.O. Box 15</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>2/13/33</u>	9. AGE (In years last birthday) <u>33</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trailer park</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles F Browne</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Murray</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES KOREAN CONF.</u>		16. SOCIAL SECURITY NO. <u>22-20-1065</u>		17. INFORMANT <u>wife</u>	
18. <u>1965-21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Antecedent Causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>Radiation Fibrosis of Lung</u> DUE TO (B) <u>Cancer of Thyroid</u> DUE TO (C) <u>ACTH Secretion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u> <u>6 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 2</u> 19 <u>66</u> to <u>May 20</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>May 20</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W.C. Standiford</u>				23B. DATE SIGNED <u>6/20/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>M.D.</u>				23D. ADDRESS <u>M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-24-66</u>		24C. NAME of CEMETERY or CREMATORY <u>ST. GEORGES Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>CLARKSVILLE, DELA.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1966</u>		25B. NAME OF REGISTRAR <u>R. E. E. Farkner</u>		25C. FUNERAL DIRECTOR <u>A. Douglas Nelson, Frankford, Del.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06624		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06624	
M.E. CASE NO.		CERTIFICATE OF DEATH		6-29-66 535 P M.	
1. NAME OF DECEASED (Type or Print) E. LOTTIE PURCELL		2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
South Baltimore General Hospital		Maryland			
43		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
HOSPITAL		Baltimore 25-04			
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	
8. DATE OF BIRTH 09/21/1882		9. AGE (In years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Alex McCollum	
14. MOTHER'S MAIDEN NAME Alvord		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Chart -		ADDRESS		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO (L) CVA		INTERVAL BETWEEN ONSET AND DEATH 64 DAYS	
ANTECEDENT CAUSES		(B) DUE TO		(C) BROCKHOFF PNEUMONIA	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		HAS UDD		10+ yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. J. Hoffa		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/29/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
23D. ADDRESS		24B. DATE 7-5-66		24C. NAME of CEMETERY or CREMATORY Grandview Cemetery	
24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Allentown, Penna.	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966	
24D. LOCATION (City, town, or county) (State)		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR S. J. Cully, Funeral Home 237 Patuxent Ave	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

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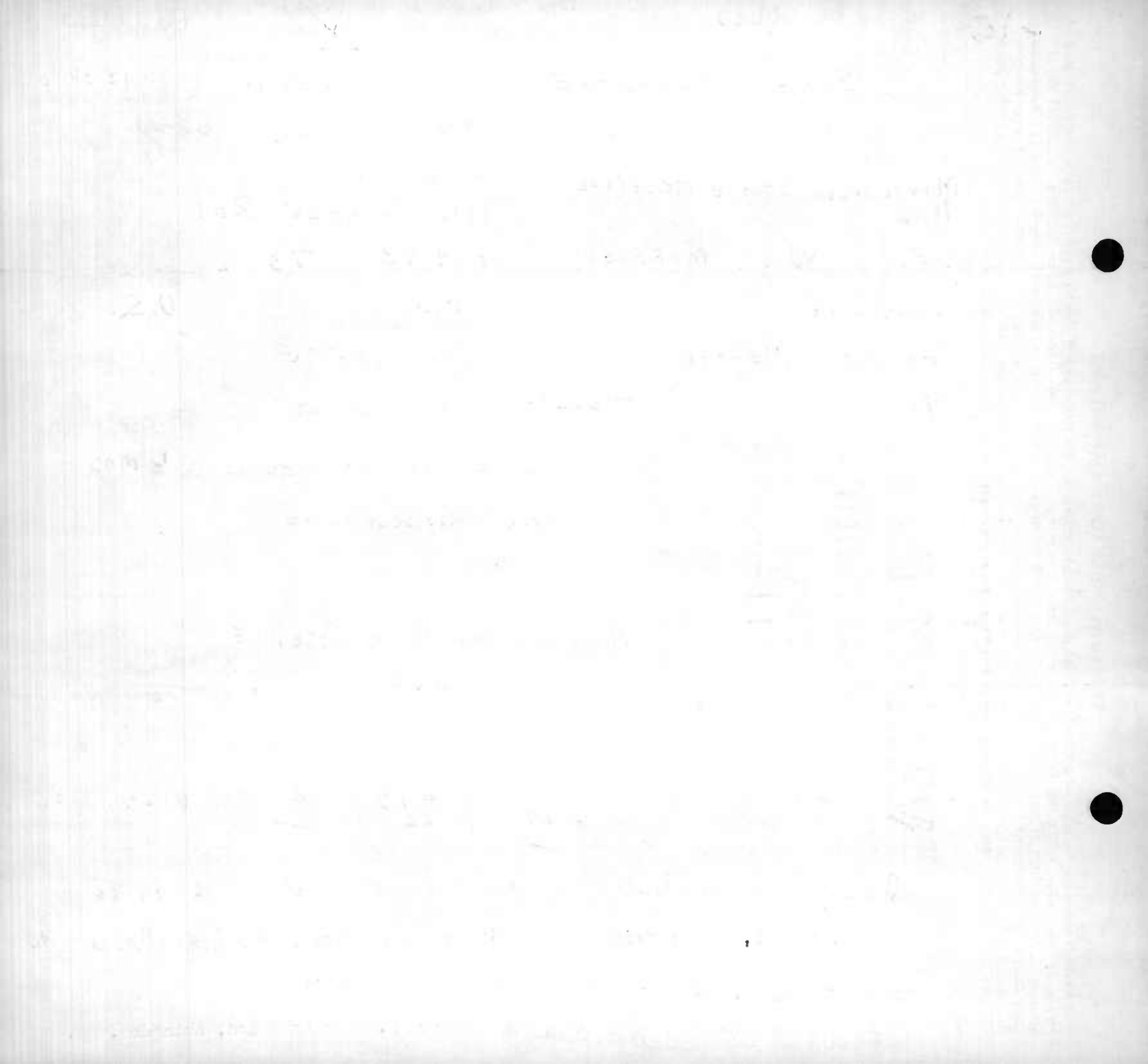
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06625</u>	
BIRTH NO. <u>66 06625</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>CLARA</u>		1. NAME OF DECEASED (Type or Print) <u>ELSA I SCHNEPFE</u>		2. DATE AND HOUR OF DEATH <u>6-29-66</u> <u>12:30 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MONTEBELLO STATE HOSPITAL</u> <u>91</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Harford</u> <u>62-00</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>EDGEWOOD</u> D. STREET ADDRESS (If rural, give location) <u>1915 TRIMBLE RD.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>4-14-93</u>	9. AGE (In years lost birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>HENRY MERKEL</u>			14. MOTHER'S MAIDEN NAME <u>EMMA HEISE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-34-1488</u>	17. INFORMANT ADDRESS <u>HOSP. RECORD</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRAL THROMBOSIS</u>		CAUSE OF DEATH (A) DUE TO <u>ARTERIO SCLEROSIS</u> (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ARTERIOSCLEROTIC HEART DISEASE</u>					
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>4-13</u> 19 <u>66</u> to <u>6-29</u> 19 <u>66</u> , that (H) (we) last saw the deceased alive on <u>6-29</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Irving L. Cooperstein</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-29-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Irving L. Cooperstein</u>		23D. ADDRESS M.D. <u>MONTEBELLO STATE HOSPITAL, BALTO. - MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>July 2, 1966</u>	24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard K. McComas & Son, Abingdon, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

47-02-39 NIW		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 06626</u>	
BIRTH NO. <u>66 06626</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Rose KluczniK (ROSE KLUCZNIK)</u>		2. DATE AND HOUR OF DEATH <u>6/28/66</u> <u>112¹⁸ PM</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u> B. COUNTY	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		D. STREET ADDRESS (If rural, give location) <u>2238 Cambridge Street - 21231</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u>	8. DATE OF BIRTH <u>4/25/84</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Piechnicki</u>			
14. MOTHER'S MAIDEN NAME <u>Jadwiga (Hedwig) Kotyras</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>			
16. SOCIAL SECURITY NO. <u>214-01-4537</u>		17. INFORMANT ADDRESS <u>RECORDS: BCH, 4940 Eastern Ave, Balto, Md. 21224</u>			
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>CVA</u> DUE TO (B) <u>Arteriosclerosis</u> DUE TO (C) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs</u> <u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pneumonitis</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/21/66</u> 19 to <u>6/28/66</u> 19, that (I) (we) last saw the deceased alive on <u>6/28/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William A. Emerson</u>				23B. DATE SIGNED <u>6/28/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM A. EMERSON</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave., Balto. Md. 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/2/66</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Stanislaus</u>	
24D. LOCATION (City, Town or Suburb) <u>Baltimore, Maryland</u>		24E. (Store)			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Sadowski</u>		25C. FUNERAL DIRECTOR <u>M.F. SADOWSKI & SONS, 1808 EASTERN AVE</u>	

1914

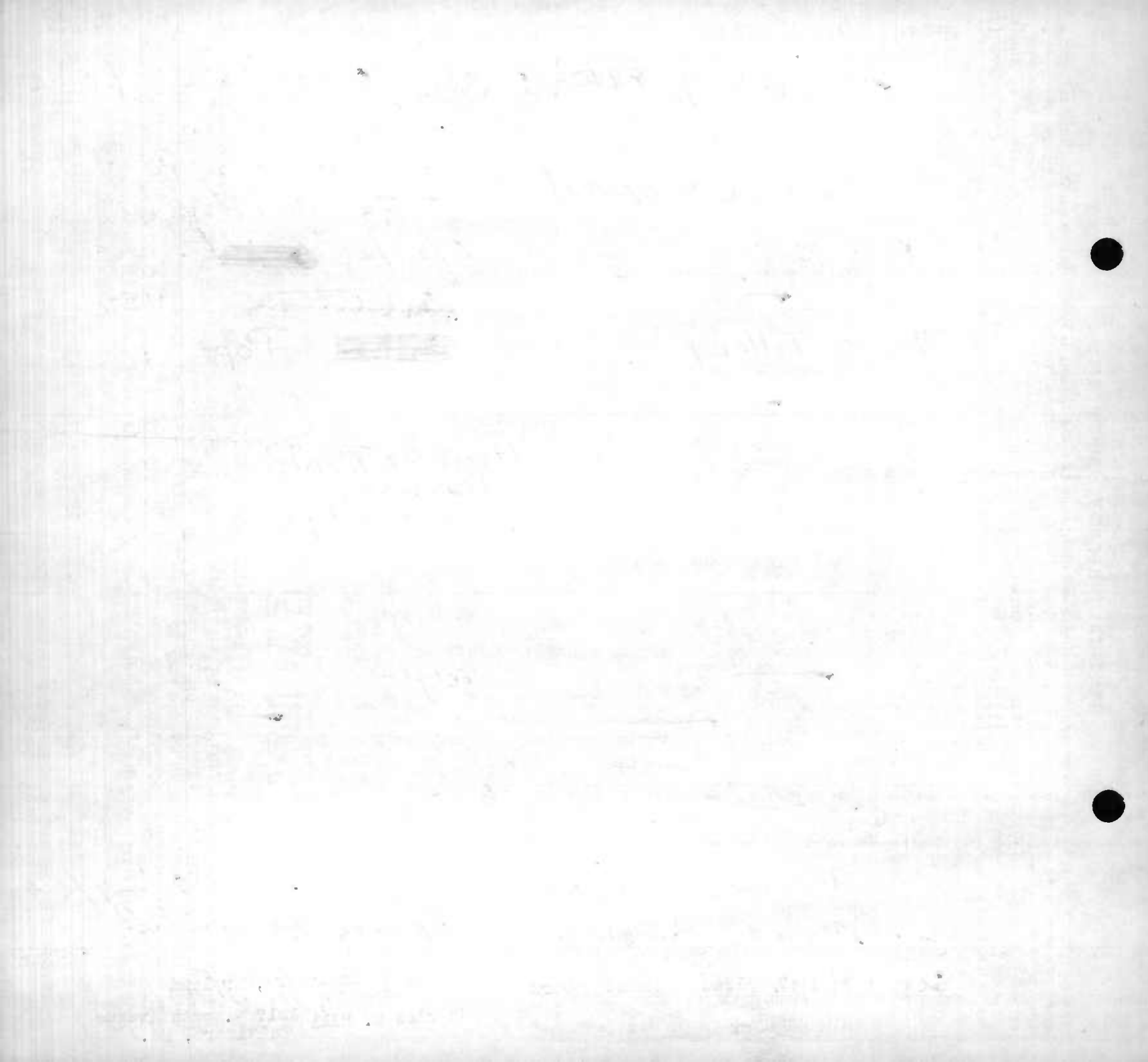
2122

2122

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06627</u>	
<div style="display: flex; justify-content: space-between;"> 66-19005 66 06627 CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Babygirl of Ethel Tillery</u> </div> <div> 2. DATE AND HOUR OF DEATH <u>6/29/66 10 a.m.</u> </div> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital</u> </div> <div> 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 14-01</u> D. STREET ADDRESS (If rural, give location) <u>1752 Park Ave. (17)</u> </div> </div>					
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>—</u>	8. DATE OF BIRTH <u>6/29/66</u>	9. AGE (In years last birthday) <u>0</u>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____ <u>5</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas Tillery</u>			14. MOTHER'S MAIDEN NAME <u>Ethel Pope</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT ADDRESS _____		
<div style="display: flex; justify-content: space-between;"> <div> 18. 723.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. </div> <div> CAUSE OF DEATH (A) <u>Hyaline Membrane Disease</u> DUE TO _____ (B) <u>Prematurity</u> DUE TO _____ (C) _____ </div> <div> INTERVAL BETWEEN ONSET AND DEATH </div> </div>					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>None</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>6/29</u> 19<u>66</u> to <u>—</u> 19<u>—</u>, that (I) <u>(we)</u> last saw the deceased alive on <u>6/29</u> 19<u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Mona Belinic</u> M.D.				23B. DATE SIGNED <u>6/29/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>MONA BELINIC</u> M.D.				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Sinai Hosp</u>		24B. DATE <u>7/2/1966</u>	24C. NAME of CEMETERY or CREMATORY <u>Mount Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles W. Hill</u> <u>1317 W. North Avenue</u> <u>Baltimore, Md.</u>	



46-72-23
FR

66 06628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 06628

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Ellen

MARY TIPPETT

2. DATE AND HOUR OF DEATH

29 June 66 0745 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)4940 Eastern Avenue
Baltimore, Maryland 21224

31 BALT. CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALT 21224-03

D. STREET ADDRESS (If rural, give location)

2324 MILLMAN ST 21205

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
single

8. DATE OF BIRTH

29 Aug 90

9. AGE (In years
last birthday)

75

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machine Operator

10B. KIND OF BUSINESS OR INDUSTRY

unknown

11. BIRTHPLACE (State or foreign country)

Maryland Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John H. Tippet

14. MOTHER'S MAIDEN NAME

Rachael Reed

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. 493X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Pneumonia

1 wk.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

Skin Ulcer of Leg 3-4 mos

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

GI Hemorrhage

2 days

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 16, 1966 to 29 June 1966,
that (I) (we) last saw the deceased alive on 29 June 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Thomas A. Otter

M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

29 Jun 66

23C. PHYSICIAN'S
NAME (Type)

THOMAS A. OTTER

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL REMOVAL (Specify)

Burial

24B. DATE

7/2/66

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT

JUN 30 1966

25B. NAME OF REGISTRAR

Robert E. Farber

25C. FUNERAL DIRECTOR

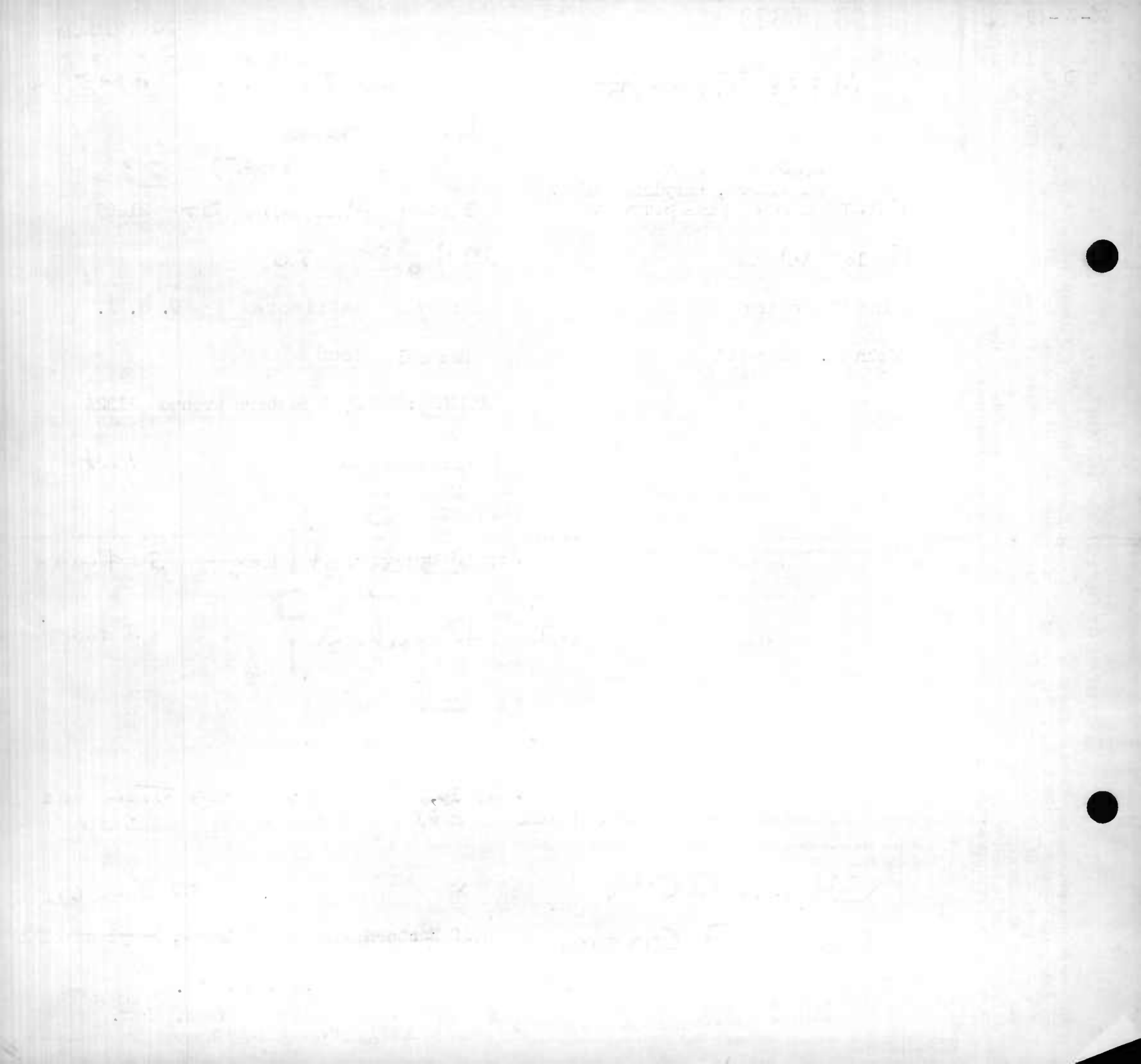
Schimunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane

FUNERAL DIRECTOR: IMPORTANT

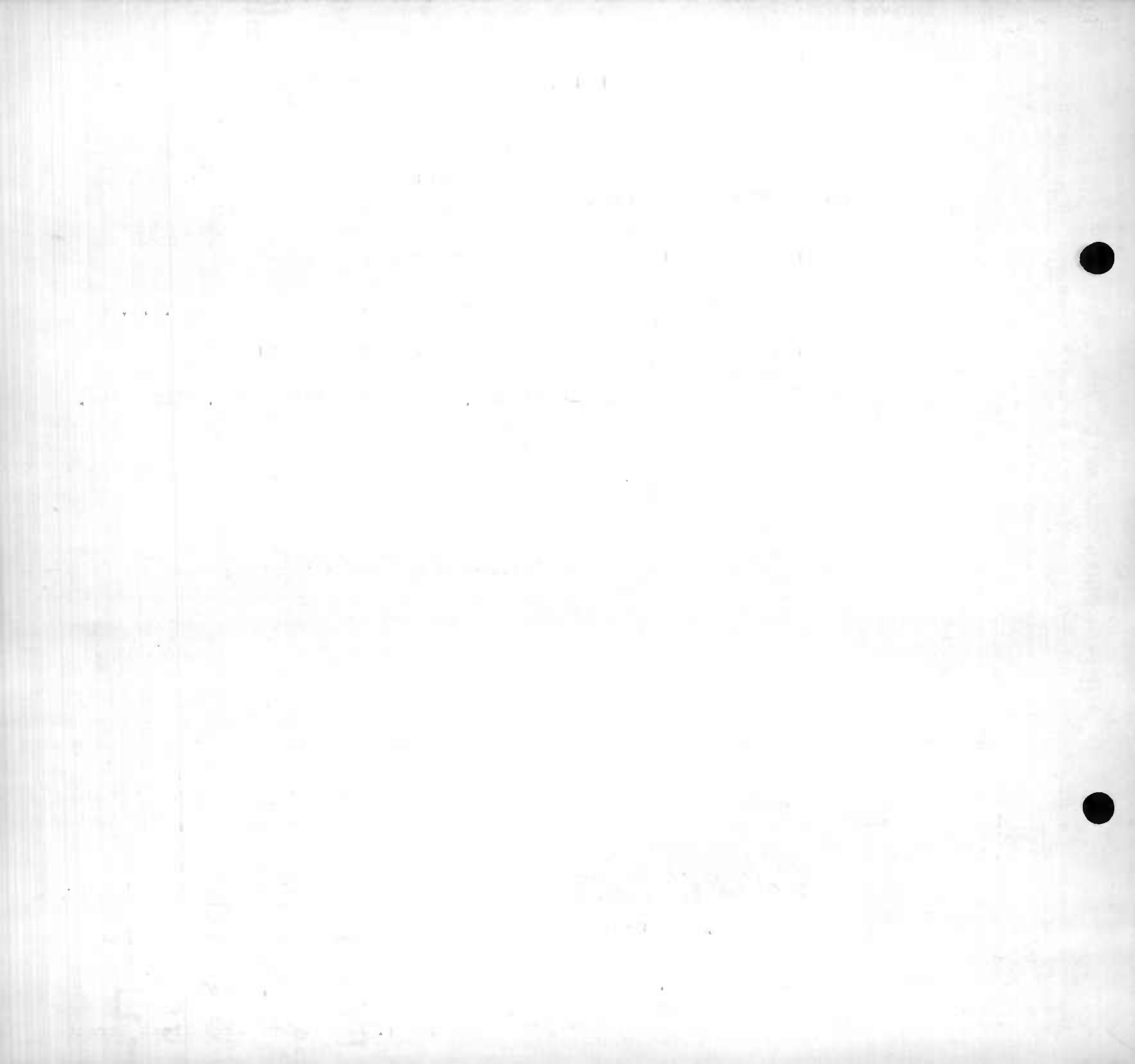
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
66 06629					66 06629						
BIRTH NO.					M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH						
GEORGE FREIMILLER					6-27-66 10.00 P M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY						
THE JOHNS HOPKINS HOSPITAL					MARYLAND						
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)						
BALTIMORE					612 S. MILTON AVENUE						
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.	
MALE		WHITE		WIDOWER		4-29-82		84			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Foreman				John Hopkins Estate				Maryland		U.S.A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
JOHN FREIMILLER						KATHERINE SCHNITZER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No						217-09-6887		Mrs. Catherine Kelly 612 S. Milton Ave.			
18. CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										(A) DUE TO	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)										Pneumonia	
ANTECEDENT CAUSES										(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C) chronic obstructive Emphysema 710 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0								No.			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)						21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 6-26-1966 to 6-27-1966, that (he) (she) last saw the deceased alive on 6-27-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
JOHN R. BURTON								M.D.		6-27-66	
23C. PHYSICIAN'S NAME (Type)								23D. ADDRESS			
JOHN R. BURTON								THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Burial				6/30/1966		Mt. Carmel Cemetery			Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
JUN 30 1966				Robert E. Farkas				Raymond L. Kaczorowski 2525 Fleet Street			



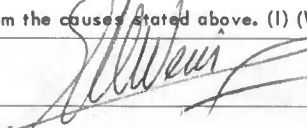
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06630</u>	
BIRTH NO. <u>66 06630</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Susie R. Eney</u>		2. DATE AND HOUR OF DEATH <u>JUN 28, 1966 8 P. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Midtown Nursing Home</u>		A. STATE <u>Md.</u> B. COUNTY _____			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1322 Lindon Ave. LINDEN</u>			
5. SEX <u>FM</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1/6/1880</u>	9. AGE (In years lost birthday) <u>86</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
13. FATHER'S NAME <u>John Powers</u>		14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Gertrude Eney 5427 Gradin Ave. 7</u>	
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardio-Respiratory Failure</u> <u>Engel's Heart Failure</u> <u>Anteroseptal C.U.H.D.</u> <u>Gen. Arteriosclerosis</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Cardio-Respiratory Failure</u> (B) <u>Engel's Heart Failure</u> (C) <u>Gen. Arteriosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Fractured Hip - Pinned</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 9 1961</u> to <u>June 28 1966</u> , that (I) (we) last saw the deceased alive on <u>June 28 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>William D. Apperford</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>William D. Apperford</u>				23D. ADDRESS <u>5501 Park Heights Dr.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Lake View</u>	
		24D. LOCATION (City, town, or county) (State) <u>Carroll County Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>J.T. Stansbury 6411 Windsor Mill</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06631				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06631	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANDREW FREDERICK DEHNE				2. DATE AND HOUR OF DEATH 6/27/66 12:15 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 29, MD.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 25-31 D. STREET ADDRESS (If rural, give location) 641 QUEENSGATE ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12/29/79	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUST F. Dehne				14. MOTHER'S MAIDEN NAME HEIDE Gertrude Zonclerherd			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. --- (705-05-3197) ---		17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ASCVD Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/25 19 66 to 6/27 19 66 that (I) (we) last saw the deceased alive on 6/27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ST. AGNES HOSPITAL, WILKENS & AVENUE				23D. ADDRESS CATON ST. AGNES HOSPITAL, WILKENS & AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE June 30, 1966	24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1966		25B. NAME OF REGISTRAR R. E. Farber		25C. FUNERAL DIRECTOR ADDRESS G. Truman Schwab 3512 Frederick Ave. Balto.			

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66 06632

BALTIMORE CITY HEALTH DEPARTMENT

66 06632

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ERNEST

RICH

2. DATE AND HOUR PRONOUNCED DEAD

June 26, 1966

4:20 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1841 Presstman Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 3 1907

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Laborer

11. BIRTHPLACE (State or foreign country)

Wash D.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Oscar Rich

14. MOTHER'S MAIDEN NAME

Lucile Rich

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

2

16. SOCIAL
SECURITY NO.

215-09-9134

17. INFORMANT

Lucile Rich

ADDRESS

2703 Cherry
45th Rd

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(A) Arteriosclerotic Heart Disease.
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

If
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/27/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-1-66

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

Baltimore

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 30 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Mrs. Frances A. Hummer

ADDRESS

578 W
Biddle St

WALLEY BROOK

NO. 100

1875



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES MALCZEWSKI

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1966

11:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1341 Broening Highway

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4-4-1890

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Air Operator

10B. KIND OF BUSINESS OR INDUSTRY

Arundel Corp

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Vincent Malczewski

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

214012094

17. INFORMANT

Cecelia Malczewski as D

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-29-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-2-66

23C. NAME OF CEMETERY or CREMATORY

St Stanislaus

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 30 1966

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Walter Dabrowski

ADDRESS

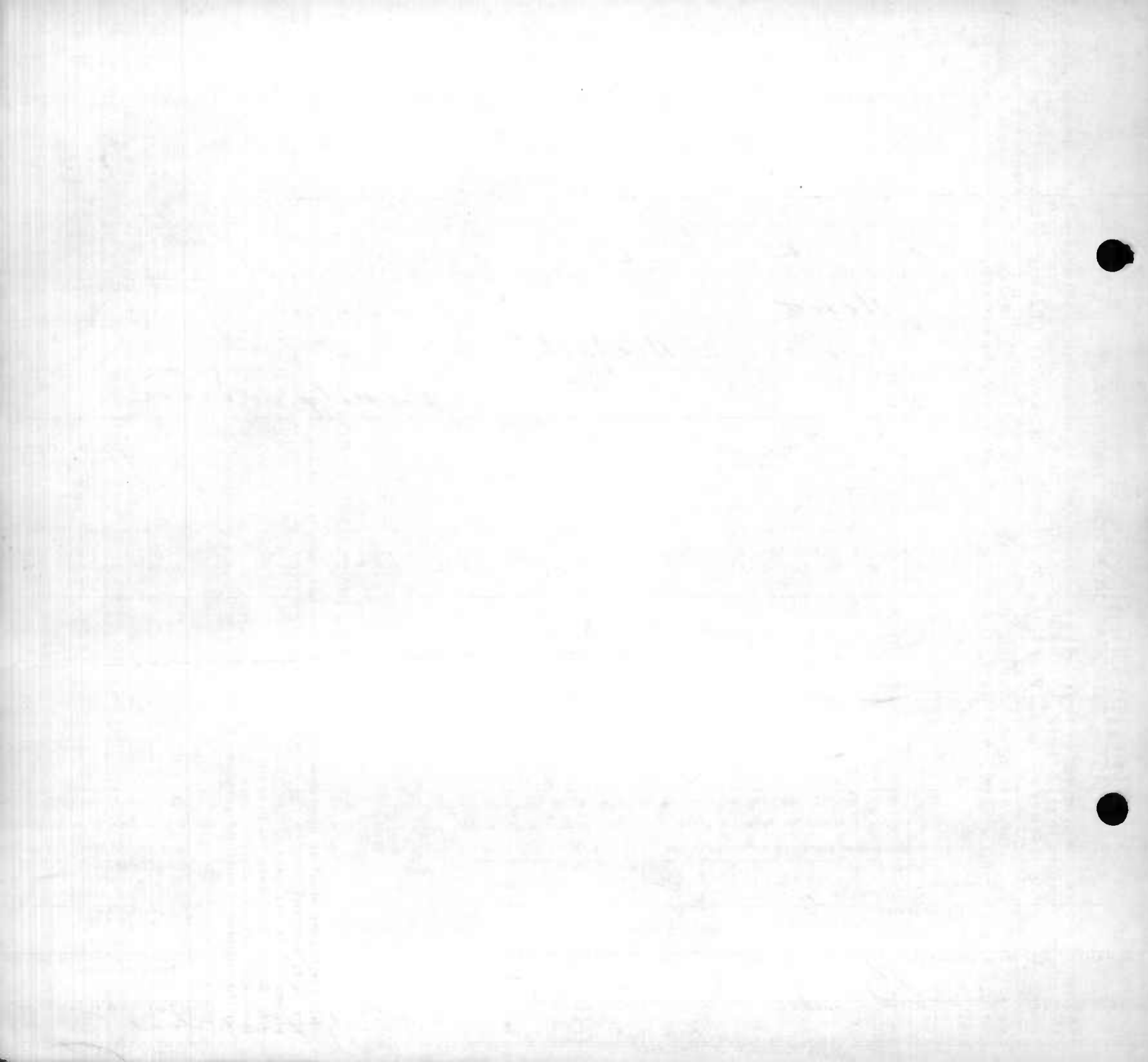
1005 Dundalk Avenue 21224, City

VALLEY COLLEGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

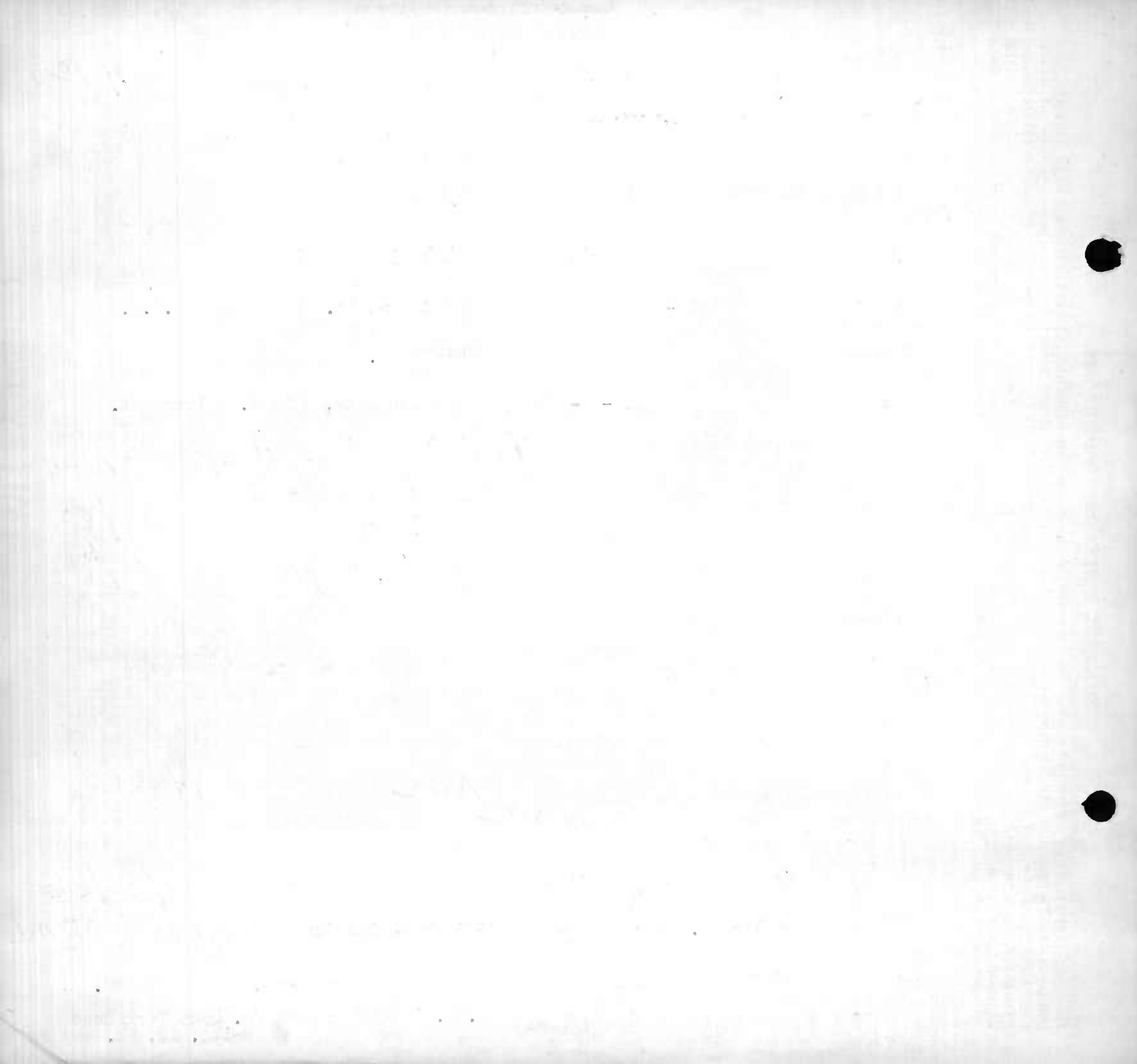
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06634	
BIRTH NO. 66 06634		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>ELLIOTT MARY E.</i>		2. DATE AND HOUR OF DEATH <i>6/30/66 1:55 A M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hospital 43</i>		A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>			
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>W</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>8-26-86</i>	
13. FATHER'S NAME <i>Sylvester Norfolk</i>		14. MOTHER'S MAIDEN NAME <i>?</i>		9. AGE (In years last birthday) <i>79</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family - Same</i> ADDRESS	
18. <i>331 X & 1260 X</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <i>CUA (C)</i>		<i>96 Hrs</i>	
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO			
ANTECEDENT CAUSES		(C) <i>HYPERTENSION</i>		<i>20 yrs</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>DIABETES MELLITUS</i>		<i>15 yrs</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Edward A Hill</i>				23B. DATE SIGNED <i>6/30/66</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>7-2-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Olivet</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Ed Caffrey - 130 E. Towson Ave.</i> ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 66 06635	
BIRTH NO. 66 06635		M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Odellia Dortha Pfeifer				2. DATE AND HOUR OF DEATH June 28, 1966 11:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 28-04	
729 Brookwood Road				C. CITY OR TOWN Baltimore		(If outside city limits, write RURAL and give township)	
				D. STREET ADDRESS (If rural, give location)		729 Brookwood Road	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 5/2/1893	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Companion		10B. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-40-4948		17. INFORMANT ADDRESS Miss Helen Tate, 2822 N. Calvert St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema Acute Anterosclerotic Cardio-vascular Disease Coronary Artery Disease Right				CAUSE OF DEATH (A) DUE TO (B) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 hours 5 years 2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from None 19 to None 19, that (I) (we) last saw the deceased alive on None 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William E. McGrath M.D.				23B. DATE SIGNED 6/30/66			
23C. PHYSICIAN'S NAME (Type) William E. McGrath				23D. ADDRESS M.D. 1303 Frederick Road Catonsville 28 Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/1966		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06636		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06636	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) Mrs. Olga Schoenbrodt		2. DATE AND HOUR OF DEATH JUNE 29-1966 8:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hospital Baltimore, Md		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 6013 Edmondson Ave Baltimore, Md 21208			
5. SEX female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 4/29/1906		9. AGE (In years lost birthday) 70		10. CITIZEN OF WHAT COUNTRY? Germany	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany			
13. FATHER'S NAME Carl Gallin		14. MOTHER'S MAIDEN NAME Christine			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 8413		17. INFORMANT Mr. Peter Schoenbrodt 6013 Edmondson Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 495X I Cardiac arrest		19. CAUSE OF DEATH Infection shock		INTERVAL BETWEEN ONSET AND DEATH minutes	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Bilateral pneumonia and massive pulm. emboli		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
23. DATE OF OPERATION 2		24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? (Yes or No) YES	
26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
29. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		31. HOW DID INJURY OCCUR?	
32. I certify that (I) (this hospital) attended the deceased from JUNE 28 1966 to JUNE 29 1966, that (I) (we) last saw the deceased alive on JUNE 29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
33. SIGNATURE Juan F. Sordo		34. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		35. DATE SIGNED JUNE 29-66	
36. PHYSICIAN'S NAME (Type) JUAN F. SORDO		37. ADDRESS BON SECOURS HOSPITAL			
38. BURIAL CREMATION, READY (Specify) 2 July 66		39. DATE 2 July 66		40. NAME OF CEMETERY or CREMATORY Lanham Park	
41. LOCATION (City, town, or county) Woodlawn, Md		42. STATE (State) Md			
43. DATE REC'D BY HEALTH DEPT. JUL 1 1966		44. NAME OF REGISTRAR Robert E. Taylor		45. FUNERAL DIRECTOR Witzke Funeral Director	
46. ADDRESS JUL 1 1966		47. ADDRESS Witzke Funeral Director			

Bapt. record for Olga Dolin born 4/29/96 and bapt. 5/3/94

CONFIRMATION APPROVED BY

DATE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06637				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06637	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Laughlin, Emma H</i>				2. DATE AND HOUR OF DEATH <i>7-1-66 1608 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 Johns Hopkins Hosp</i>		(If not in hospital or institution, give street address or location)		5. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 16-05</i>			
6. STREET ADDRESS (If rural, give location) <i>2424 Edmondson Ave</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>10-1-29</i>		9. AGE (In years last birthday) <i>72</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Unknown</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>219-01-4429</i>		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CVA Probable Thrombotic episode possible pneumonia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</i>				20. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from XXXXXX <i>June 30</i> 19 <i>66</i> to <i>July 1</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>July 1</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Robb Moses</i>				23B. DATE SIGNED <i>7-1-66</i>		23C. PHYSICIAN'S NAME (Type) <i>Robb Moses</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>				24B. DATE <i>7-6-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Arbutus Md.</i>				25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>				25C. FUNERAL DIRECTOR ADDRESS <i>MORTON + DYOTT 1701 LAWRENS</i>			

October

10.1.10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06638		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06638	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Harrison, John		2. DATE AND HOUR OF DEATH 6-28-66 6:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		BALTIMORE	
Baltimore City Hospitals 4940 EASTERN AVENUE #21224		818 ABBOTT CT. #21202		10-02	
6. SEX M	7. RACE N	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	9. DATE OF BIRTH 3-26-90	10. AGE (In years lost birthday) 76	11. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABORER		NONE		MARYLAND	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-12-7576		17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVENUE	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH ASCVD		INTERVAL BETWEEN ONSET AND DEATH 5 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-26-1966 to 6-28-1966, that (I) (we) last saw the deceased alive on 6-28-1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alex Silverman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-28-66	
23C. PHYSICIAN'S NAME (Type) DR. ALEX SILVERMAN		23D. ADDRESS 4940 EASTERN AVE. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-5-66		24C. NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY LANDOVER, MARYLAND	
25A. DATE RECEIVED BY HEALTH DEPT. JUL 1 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS MORTON + Dye II. 1701 Laurens ST.	

Continued from page 1

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2-56-20

2-56-20 11 11 11

of Bill City Hall

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. **66 06639**

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

NATHANIEL

JONES

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1966

1:35 A

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

606 W. LaFayette Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

7-20-1914

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Con tractor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Durham, N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNK.

14. MOTHER'S MAIDEN NAME

Sulig Sches

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

247-12-2508

17. INFORMANT

Mrs Marriel Jones

ADDRESS

606 W. LaFayette Avenue

18.

443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) **Hypertensive and Arteriosclerotic**

Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/30/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-5-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

Baltimore

(City, town, or county)

(State)

md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 1 1966

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR


Mortone Dyett, F.H.

ADDRESS

1701 Laurens St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06640				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06640	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Lucille Jackson				2. DATE AND HOUR OF DEATH June 30, 1966 5:45 A.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-01 D. STREET ADDRESS (If rural, give location) 1316 Woodyear Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 12-17-32	9. AGE (In years last birthday) 34	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Haywood Jackson				
14. MOTHER'S MAIDEN NAME Virginia Christian			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Virginia Christain 1315 Stockton St.				
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Diabetes Mellitus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 27, 1966 to June 30, 1966 , that (I) (we) last saw the deceased alive on June 30, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED June 30, 1966			
23C. PHYSICIAN'S NAME (Type) Rigaud				23D. ADDRESS M.D. 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-66		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. JUL 1 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS George G. Kelson 1345 Calhoun St.			

14

15-16-17

18-19-20

21-22-23

24-25-26

27

28-29-30

31-32-33

X

34-35-36

37-38-39

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 64-30157 66 06641				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06641	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Charles Nelson				June 29, 1966 9:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Provident Hospital 1514 Division Street Baltimore, Maryland				Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 540 Baker Street			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		Negro		Never Married		October 26, 1964	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
1 yr. 8 mo.				Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
				Mary Johnson 540 Baker Street			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						Mother 540 Baker Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) Encephalopathy			
ANTECEDENT CAUSES				(B) Toxicity (Probably)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Pyelonephritis, Cystitis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from June 25, 1966 to June 29, 1966, that (I) (we) last saw the deceased alive on June 29, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Lionel C. Rose						June 29, 1966	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Lionel C. Rose				1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-1-66		Mt. Auburn Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUL 1 1966		Robert E. Jenkins		George C. Nelson 1348 N. Calhoun St.			

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66 06642

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 06642

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LOUIS POZKOWSKI

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1966

6:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CHURCH HOME & HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2040 E. Pratt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

AUG. 7, 1891

9. AGE (In years last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

STEEL TITIN PRODUCT

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

FRANK POZKOWSKI

14. MOTHER'S MAIDEN NAME

KATARZYNA FELLIRAK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

FRANK MURAWSKI 4302 SEIDEL AVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular

(A) DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-1-66

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

7-4-1966 HOLY ROSARY CEM

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

BALTIMORE

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

JUL 1 1966

24B. NAME OF REGISTRAR

Robert E. Fawcett

24C. FUNERAL DIRECTOR

JOHN M WEBER & SONS INC 4015 CHESTER ST

WALLACE FORNIGI

HAS CONTENT

NO. 4

WALLACE FORNIGI

WALLACE

WALLACE

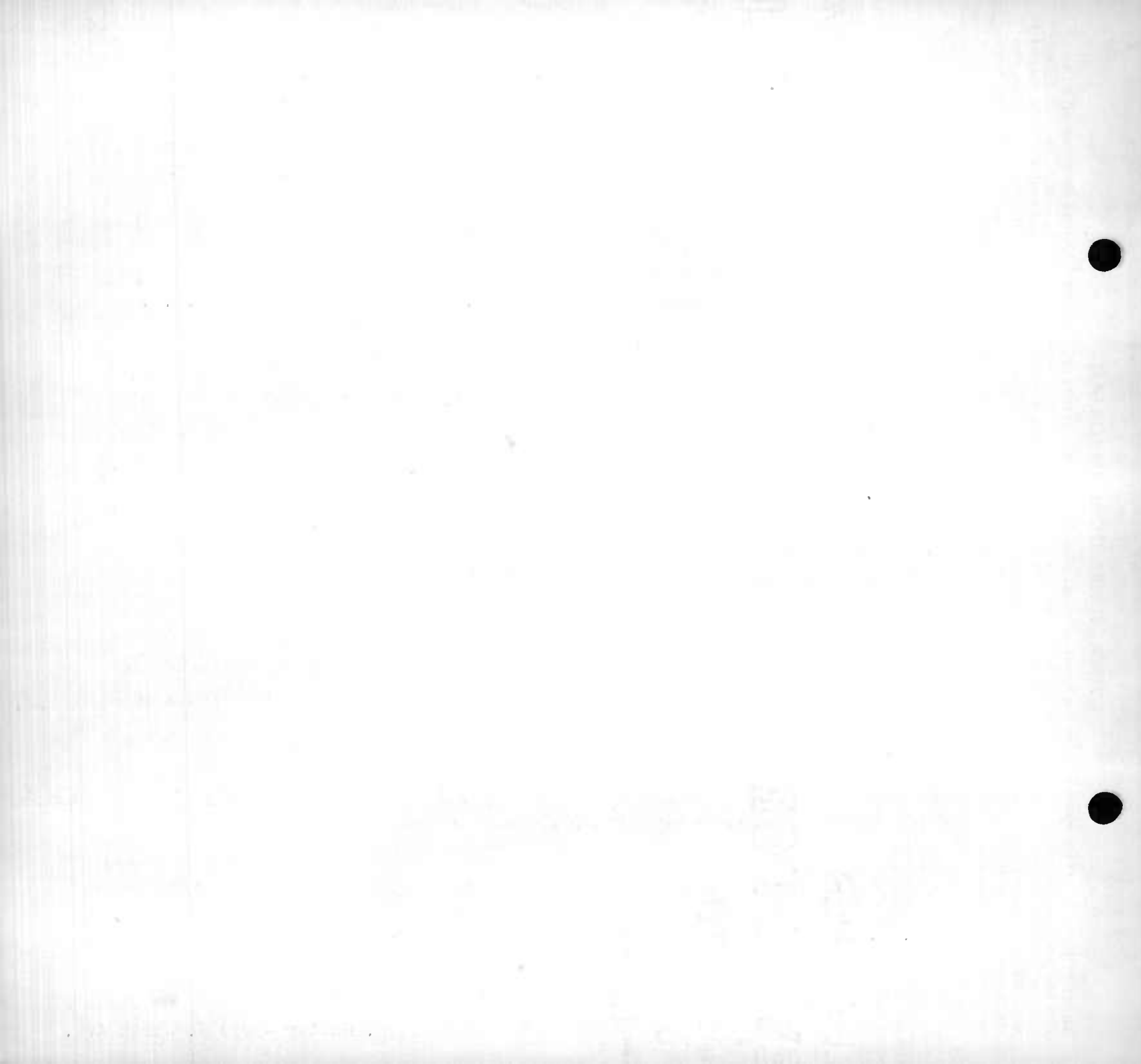
WALLACE

WALLACE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

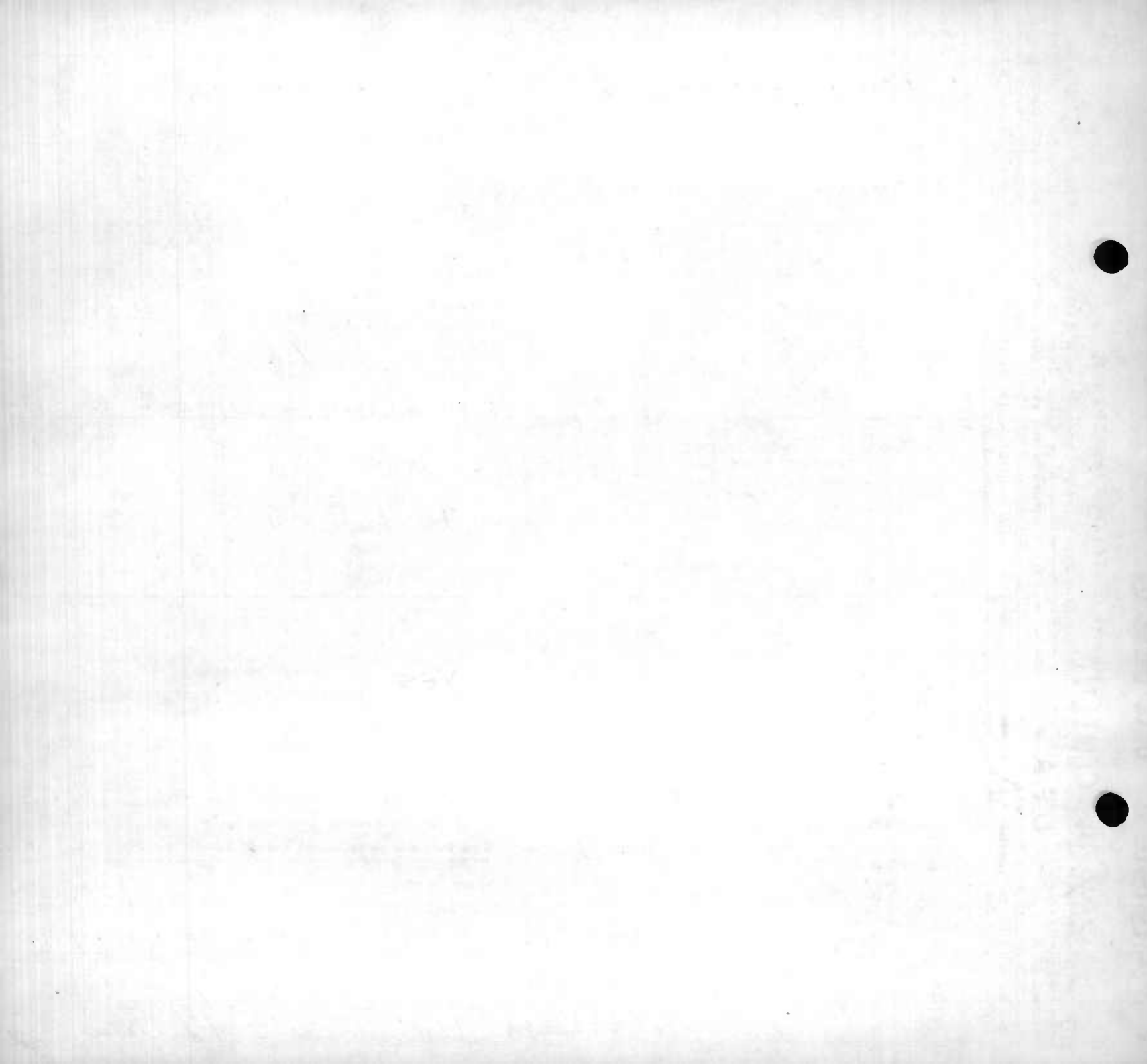
<p>BIRTH NO. 66 06643</p> <p>CERTIFICATE OF DEATH</p>		<p>Baltimore City Health Department</p> <p>Registered No. 66 06643</p>	
<p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) Abraham L. Lewis</p>		<p>2. DATE AND HOUR OF DEATH June 28, 1966</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>1506 McCulloh Street</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY 14-02</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p> <p>D. STREET ADDRESS (If rural, give location) 1506 McCulloh Street</p>	
<p>5. SEX Male</p>	<p>6. RACE Colored</p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single</p>	<p>8. DATE OF BIRTH 1/16/1895</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Ship Yard</p>	<p>9. AGE (In years last birthday) 71</p> <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>11. BIRTHPLACE (State or foreign country) St. George-Granado B W I</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME William Lewis</p>		<p>14. MOTHER'S MAIDEN NAME Alice Langford</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>	<p>17. INFORMANT ADDRESS Annie Gordon-1506 McCulloh Street</p>
<p>18. I 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cardiovascular Disease DUE TO (B) Ch Arthritis DUE TO (C) _____</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 2 yr 2 yr</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 5/8, 1965 to 6/28, 1966, that (I) (we) lost saw the deceased alive on 6/12, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE W. Atwell Jones</p>		<p>23B. DATE SIGNED 6/29/66</p>	
<p>23C. PHYSICIAN'S NAME (Type) Dr. W. Atwell Jones</p>		<p>23D. ADDRESS 554 Dolphin Street</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>	<p>24B. DATE 7/2/66</p>	<p>24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery</p>	<p>24D. LOCATION (City, town, or county) (State) Baltimore Maryland</p>
<p>25A. DATE REC'D JUL 1 1966</p>		<p>25B. NAME OF REGISTRAR Herbert E. Nutter</p>	
<p>25C. FUNERAL DIRECTOR</p>		<p>ADDRESS Herbert E. Nutter -3035 W. North Ave.</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 06644		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06644	
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.				6-30-66 5:15 A.M.	
1. NAME OF DECEASED (Type or Print)					
LEWIS, LEATHA					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
		A. STATE		B. COUNTY	
		MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
(If not in hospital or institution, give street address or location)		BALTIMORE		16-07	
LUTHERAN HOSPITAL OF MARYLAND		D. STREET ADDRESS (If rural, give location)			
46		3012 PRESTMAN ST			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
♀	Q	WIDOW	10-3-16	49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				North Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Solomon Crawford		Mary Lockhart		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				RUTH GAITHER (FRIEND) 3001 BRIGHTON	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) HEPATIC COMA			
ANTECEDENT CAUSES		(B) LIVER CIRRHOSIS			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 5-28 19 66 to 6-30 19 66, that (I) (we) last saw the deceased alive on 6-30-19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
DAHLIA QUINADA				6-30-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DAHLIA QUINADA		LUTHERAN HOSP. OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Removal	7-1-66			Gastonia, North Carolina	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 1 1966		Robert E. Taylor		Arlington S. Phillips 1721-27th N. Monroeville	



1
H-630

66 06645

BALTIMORE CITY HEALTH DEPARTMENT

66 06645

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Clarence Harrod

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1966

9:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4416 Wrenwood Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4416 Wrenwood Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

6-8-55

9. AGE (In years
last birthday)

11

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Clarence Trusty

14. MOTHER'S MAIDEN NAME

Irene Harrod

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Irene Flack 4416 Wrenwood Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Intestinal gangrene
DUE TO volvulus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Partial

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED20A. AUTOPSY? (Yes or No)
Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-29-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-2-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

Balto; Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 1 1966

R. E. Finkbeiner

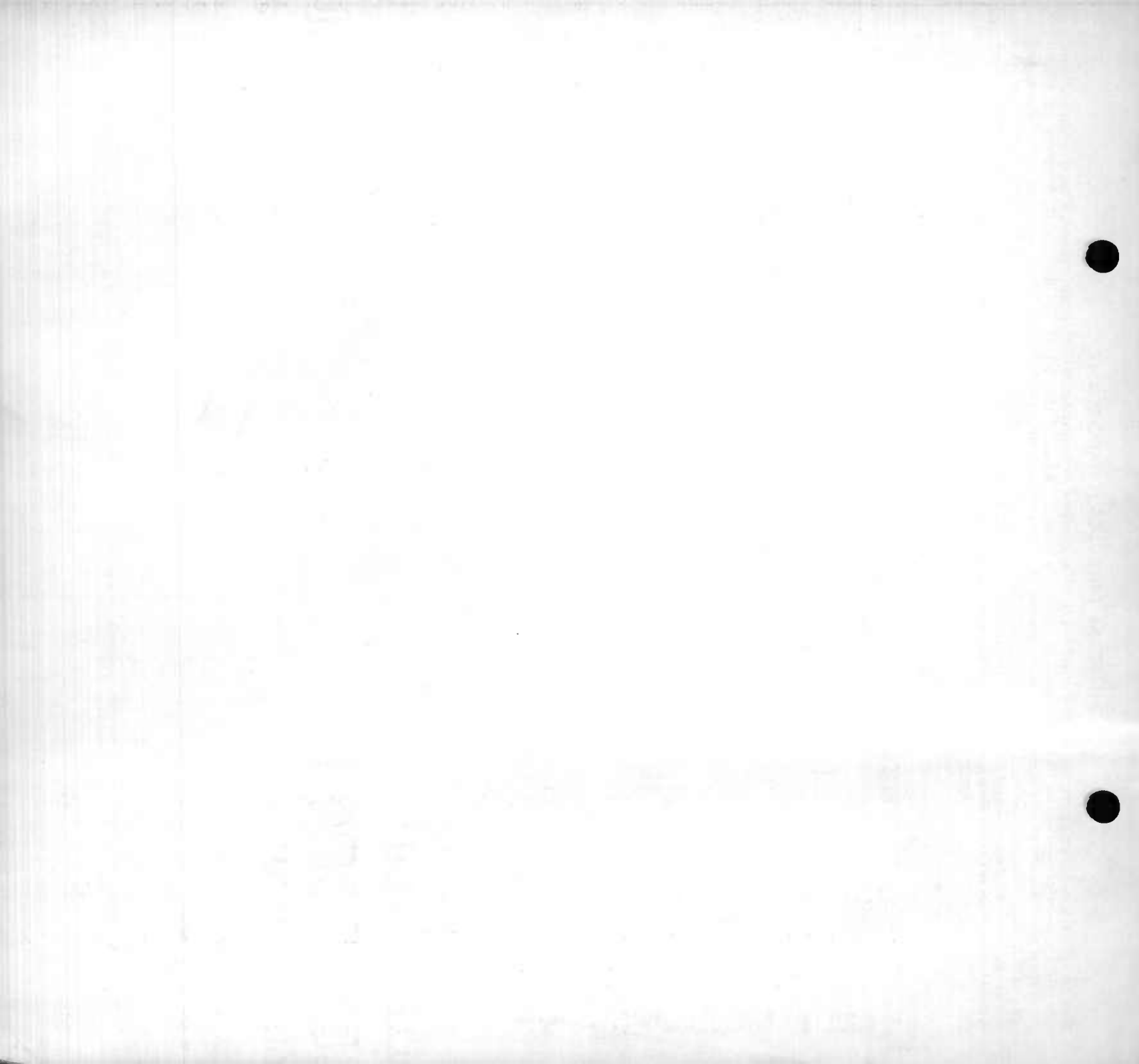
George C. Kaban 1348 Calhoun St.

WALLLEY KORTGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06646	
BIRTH NO. 66 06646		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Dixon, Helen</i>		2. DATE AND HOUR OF DEATH <i>7/1/66</i> <i>11⁰⁰</i> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hosp</i>		A. STATE <i>Md</i> B. COUNTY <i>Balto.</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>14-03</i>			
D. STREET ADDRESS (If rural, give location)		<i>3412 E. Hing St</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>10/18/99</i>	9. AGE (In years lost birthday) <i>66</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>WILLIAM BALL</i>		14. MOTHER'S MAIDEN NAME <i>ADDIE</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>William Dixon 3412 E Hing St</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <i>Acute Myocardial Infarct</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>None Known</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/1/66</i> <i>1966</i> to <i>7/1</i> <i>1966</i> , that (I) (we) last saw the deceased alive on <i>7/1</i> <i>1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harmon J Eyre</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/1/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Harmon J Eyre</i>		23D. ADDRESS <i>550 No Broadway Baltimore Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-7-66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem Pk.</i>	
24D. LOCATION (City, town, or county) <i>Arbutus Md.</i>		24E. STATE <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>George Kelson</i>	
				ADDRESS <i>1348 Calhoun St</i>	



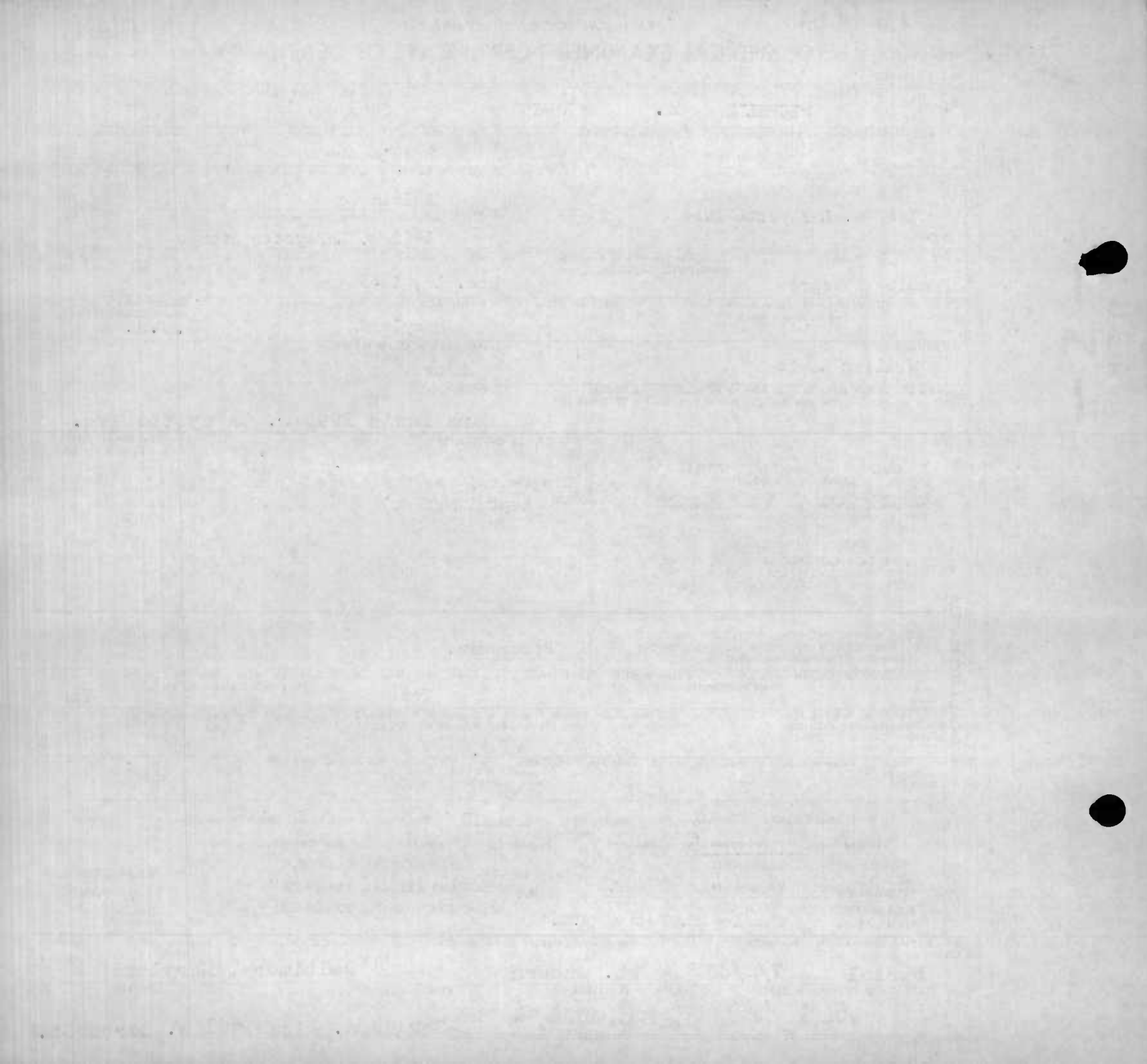
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66 06647

BALTIMORE CITY HEALTH DEPARTMENT

66 06647

BIRTH NO. 65-36995		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) MICHELLE Z. LEWIS			2. DATE AND HOUR PRONOUNCED DEAD June 30, 1966 9:45 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1945 W. LaFayette Avenue			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1945 W. LaFayette Avenue		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH Dec. 17, 1965	9. AGE (in years last birthday) 6	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Lewis			14. MOTHER'S MAIDEN NAME Edna		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Edna Lewis 1945 W. LaFayette Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Congenital Heart Disease (Interventricular Septal Defect) INTERVAL BETWEEN ONSET AND DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty, M.D. EXAMINER'S NAME (Type) DATE SIGNED 6/30/66 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7/2/66		23C. NAME of CEMETERY or CREMATORY Mt. Auburn	
24A. DATE REC'D BY HEALTH DEPT. JUL 1 1966		24B. NAME OF REGISTRAR Robert E. Jenkins		24C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barro St.	
23D. LOCATION (City, town, or county) Baltimore, Maryland		23E. STATE (State) Maryland			



66 06648

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 06648

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)LAWRENCE FRANK
~~FRANK~~ SURASKY

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1966

4:12 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4315 Forrest Park Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

MARCH 6, 1945

9. AGE (in years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SCHOOL

10B. KIND OF BUSINESS OR INDUSTRY

Student

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

ALEX SURASKY

14. MOTHER'S M maiden name

KAY LEBOW

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

212-48-7302

17. INFORMANT

ADDRESS

MR. ALEX SURASKY, 4315 FOREST PARK AVENUE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cyanide poisoning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

4315 Forrest Park Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

6

29

66

?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

ingested cyanide

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-29-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

6/30/66

23C. NAME OF CEMETERY or CREMATORY

CHIZUK AMUNO

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

JUL 1 1966

24B. NAME OF REGISTRAR

Robert E. Feilbush

24C. FUNERAL DIRECTOR

ADDRESS

SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN

WALL STREET

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06649		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06649	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William Gottlieb		2. DATE AND HOUR OF DEATH 6/29/66 8:55 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY Balto		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital of Balto. Inc.		D. STREET ADDRESS (If rural, give location) 17 Warren Park Dr. #8 APT 1B			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 6/29/1901	9. AGE (In years lost birthday) 65	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) NEW BEDFORD, MASS	
13. FATHER'S NAME MR LOUIS GOTTLIEB		14. MOTHER'S MAIDEN NAME JULIA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT Gottlieb		ADDRESS MRS. ADA, 17 WARREN PARK DRIVE APT 1B	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 20431 Acute lymphocytic leukemia		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH ~ 2 months	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/29 1966 to 6/29 1966, that (I) (we) last saw the deceased alive on 6/29 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry John		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/29/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Sinai			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/1/66		24C. NAME OF CEMETERY or CREMATORY AGUDAS BNAI JACOB LODGE	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1966		25B. NAME OF REGISTRAR Robert E. Fairley	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 06650					CERTIFICATE OF DEATH					Registered No. 66 06650									
1. NAME OF DECEASED (Type or Print) HAROLD J. STEEL					2. DATE AND HOUR OF DEATH June 28, 1966 12 Noon M.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6320 Greenspring Avenue					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6320 Greenspring Avenue														
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced		8. DATE OF BIRTH Feb. 17, 1913		9. AGE (In years last birthday) 53		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist					10B. KIND OF BUSINESS OR INDUSTRY Gem Stores					11. BIRTHPLACE (State or foreign country) Baltimore, Maryland					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Morris Steel					14. MOTHER'S MAIDEN NAME Freida Getz														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 217-24-9880					17. INFORMANT Mrs. Mona Goorevitz					ADDRESS Randallstown, Maryland 8900 Middlebrook Ct.				
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (B) ARTERIO SCLEROSIS DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH 5 YRS. 10 YRS.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										RENAL STONES									
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 19 to JUNE 28 19 66 , that (I) (was) last saw the deceased alive on 5/27 19 66 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.																			
23A. SIGNATURE Barnett Berman, M.D.										23B. DATE SIGNED 6/29/66									
23C. PHYSICIAN'S NAME (Type) Dr. Barnett Berman										23D. ADDRESS M.D. 611 Park Avenue									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 6/30/1966					24C. NAME of CEMETERY or CREMATORY Mikao Kodesh Beth Israel					24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1966					25B. NAME OF REGISTRAR Robert E. Farkas					25C. FUNERAL DIRECTOR Sol Levinson & Bros.					ADDRESS 6010 Reisterstown Road				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06651				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06651	
1. NAME OF DECEASED (Type or Print) HARRY GLICK				2. DATE AND HOUR OF DEATH 6/28/66 5:30 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND MT. SINAI NURSING HOME				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3401 GARRISON BLVD.			
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 1895 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FLORIST		10B. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BENJAMIN GLICK				14. MOTHER'S MAIDEN NAME BESSIE PAYME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. CHARLES D. GLICK, 6601 WICKFIELD ROAD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Primary Carcinoma of Prostate with metastasis				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Arterio Sclerosis				(B) DUE TO Arterio Sclerosis		2 days	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO Arterio Sclerosis		5 yrs.	
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/28/66 to June 28 1966 , that (I) was last saw the deceased alive on 6/28/66 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.							
23A. SIGNATURE Earl L. Chambers				M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/28/66	
23C. PHYSICIAN'S NAME (Type) Earl L. Chambers -				23D. ADDRESS 4108 Liberty St. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/30/66		24C. NAME of CEMETERY or CREMATORY CHITZUK AMINO		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN			

THE AMERICAN

7th 1941

NEW YORK, N.Y.

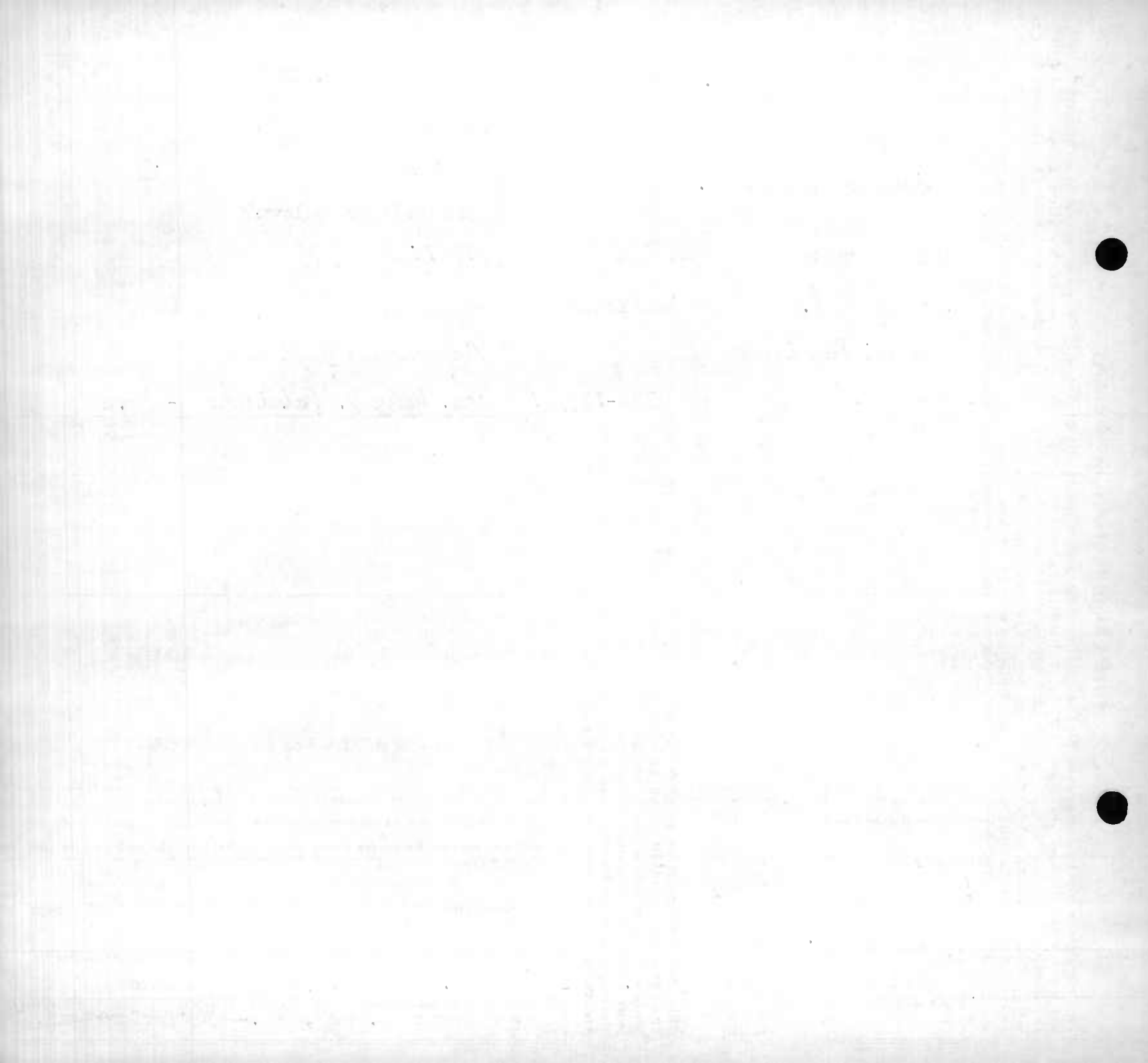
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

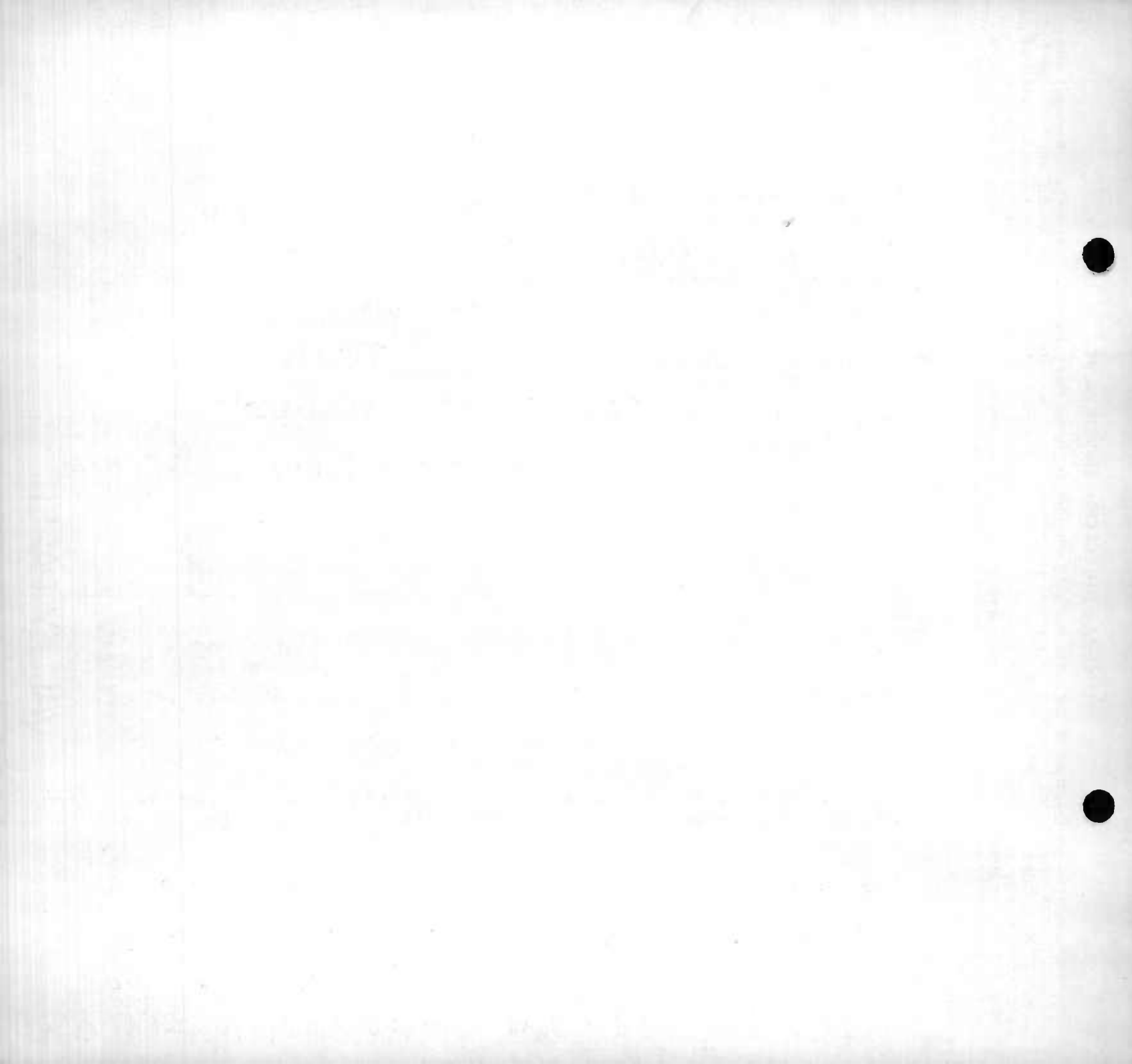
BIRTH NO. 86 06652		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 86 06652	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) FRANK C. PALMISANO			2. DATE AND HOUR OF DEATH June 30, 1966 5 ³⁰ P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4320 Walther Boulevard		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/17/1890	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Ret.		10B. KIND OF BUSINESS OR INDUSTRY Delicatessen		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel Palmisano			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-129731		17. INFORMANT Mrs. Mary J. Palmisano
			ADDRESS - Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) ASCVD DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1957 to June 30th 1966 , that (I) (we) last saw the deceased alive on June 24th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George H. Beck				23B. DATE SIGNED 7/1/66	
23C. PHYSICIAN'S NAME (Type) George H. Beck				23D. ADDRESS 6012 Harford Road, Baltimore, Md 21214	
24A. BURIAL, CREMATION, REMOVAL (specify) Burial		24B. DATE 7/5/66		24C. NAME of CEMETERY or CREMATORY Gdns. of Faith Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.	
				ADDRESS --5305 Harford Road, 14	



FUNERAL DIRECTOR: IMPORTANT

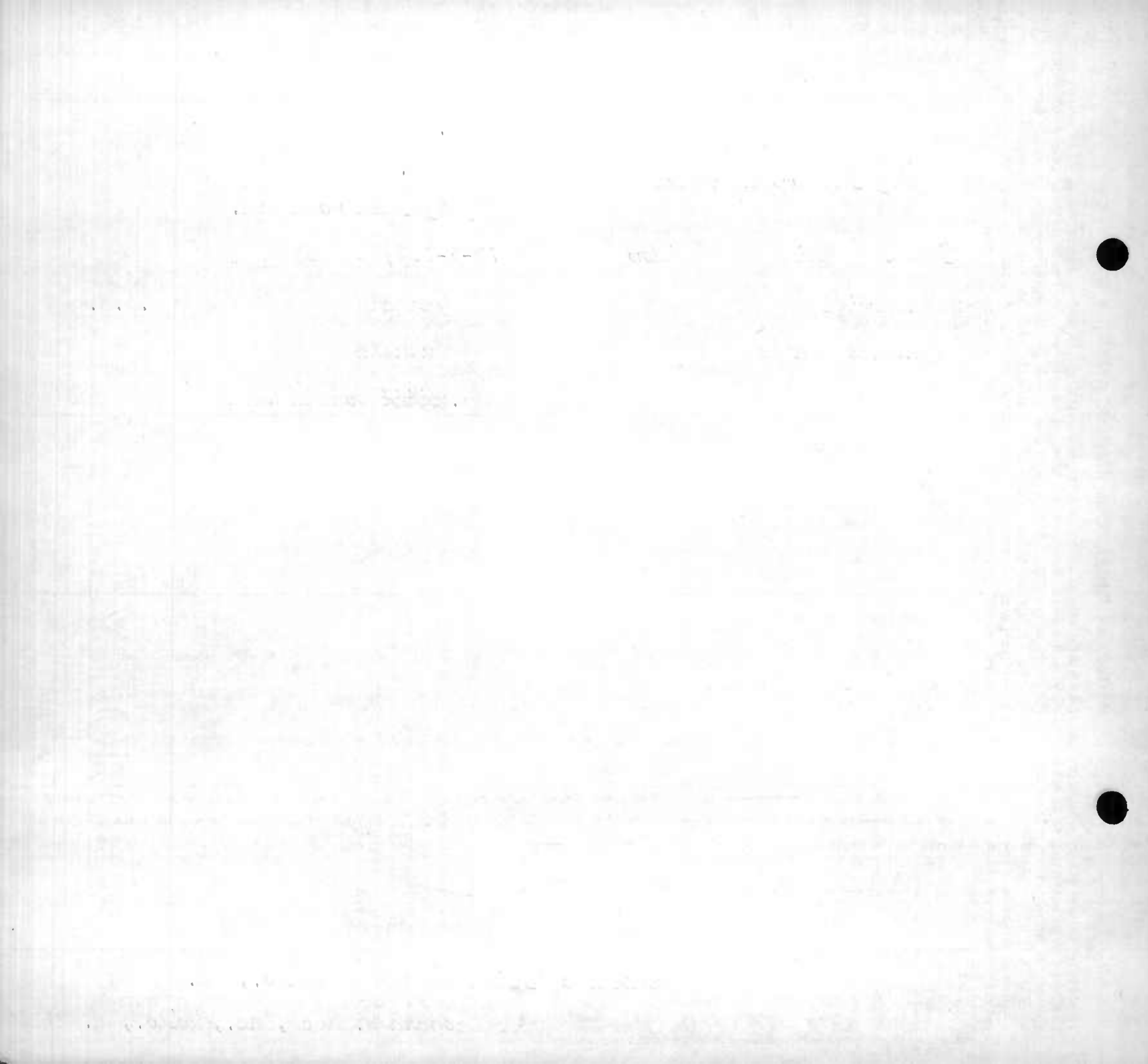
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06653				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06653	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				MAUDE E. HUSE		6-30-66 11:35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
MONTEBELLO STATE HOSPITAL				MD.			
91				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
BALTIMORE				9-02			
D. STREET ADDRESS (If rural, give location)				1634 SHADYSIDE RD.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
F		W		MARRIED		8-13-94	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				VIRGINIA		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WM. FLEET SCHOOLS				TELLIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				28-541306		HOSPITAL RECORD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I				(A) CARCINOMA OF CERVIX		20 mos.	
DUE TO				(B)			
DUE TO				(C)			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		10 WEEKS	
MYOCARDIAL INFARCTION							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (this hospital) attended the deceased from 5-10 1966 to 6-30 1966, that (we) lost saw the deceased alive on 6-30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Irving L. Cooperstein				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		6-30-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Irving L. Cooperstein				M.D. MONTEBELLO STATE HOSPITAL, BALTA-MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/5/66		Loudon Pk. Cem.		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 1 1966		Robert E. Farber		Leonard J. Puckin		5305 Hartford Rd.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

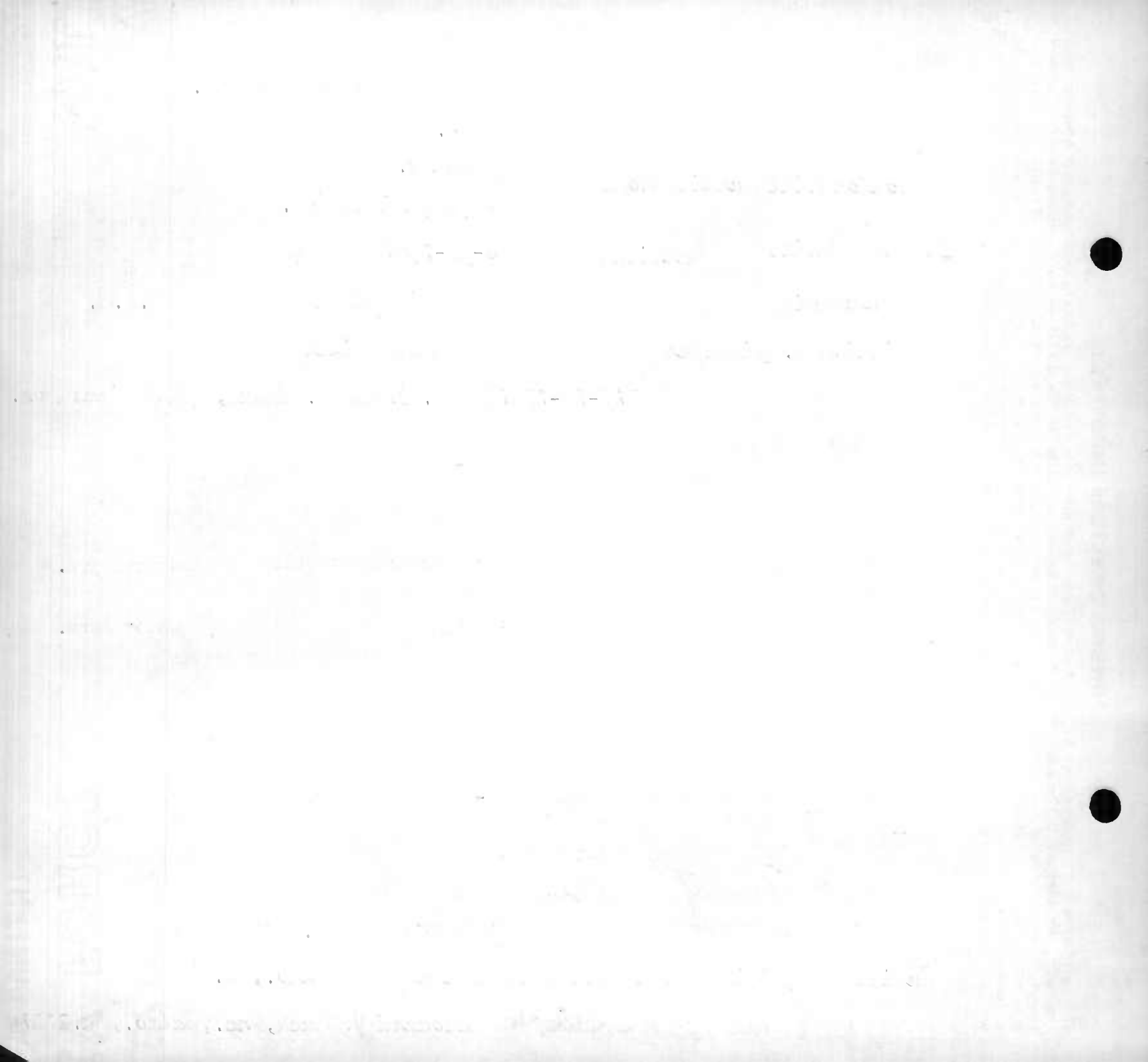
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06654		CERTIFICATE OF DEATH		Registered No. 66 06654	
1. NAME OF DECEASED (Type or Print) <i>Augusta Genusky</i>				2. DATE AND HOUR OF DEATH <i>6-30-66</i> <i>1 1 A</i> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>3005 Fleetwood Avenue</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto. #14 27-05</i> D. STREET ADDRESS (If rural, give location) <i>3005 Fleetwood Ave.</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>12-2-1879</i>		9. AGE (In years last birthday) <i>86</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Charles Radtka</i>				14. MOTHER'S MAIDEN NAME <i>Augusta ?</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Mr. John Donald Lear</i>		ADDRESS <i>(SAME)</i>		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <i>CORONARY arteriosclerosis</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>			
(B) _____ DUE TO				(C) _____ DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>June 20, 1966</i> to <i>June 30, 1966</i> , that (I) (we) last saw the deceased alive on <i>June 20, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE <i>RDonald Jandorf</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6-30-66</i>			
23C. PHYSICIAN'S NAME (Type) <i>RDonald Jandorf</i>				23D. ADDRESS <i>6077 Harford Rd</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7/2/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Gardens of Faith Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Jandorf</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc., Balto., Md.</i>		ADDRESS <i>21214</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

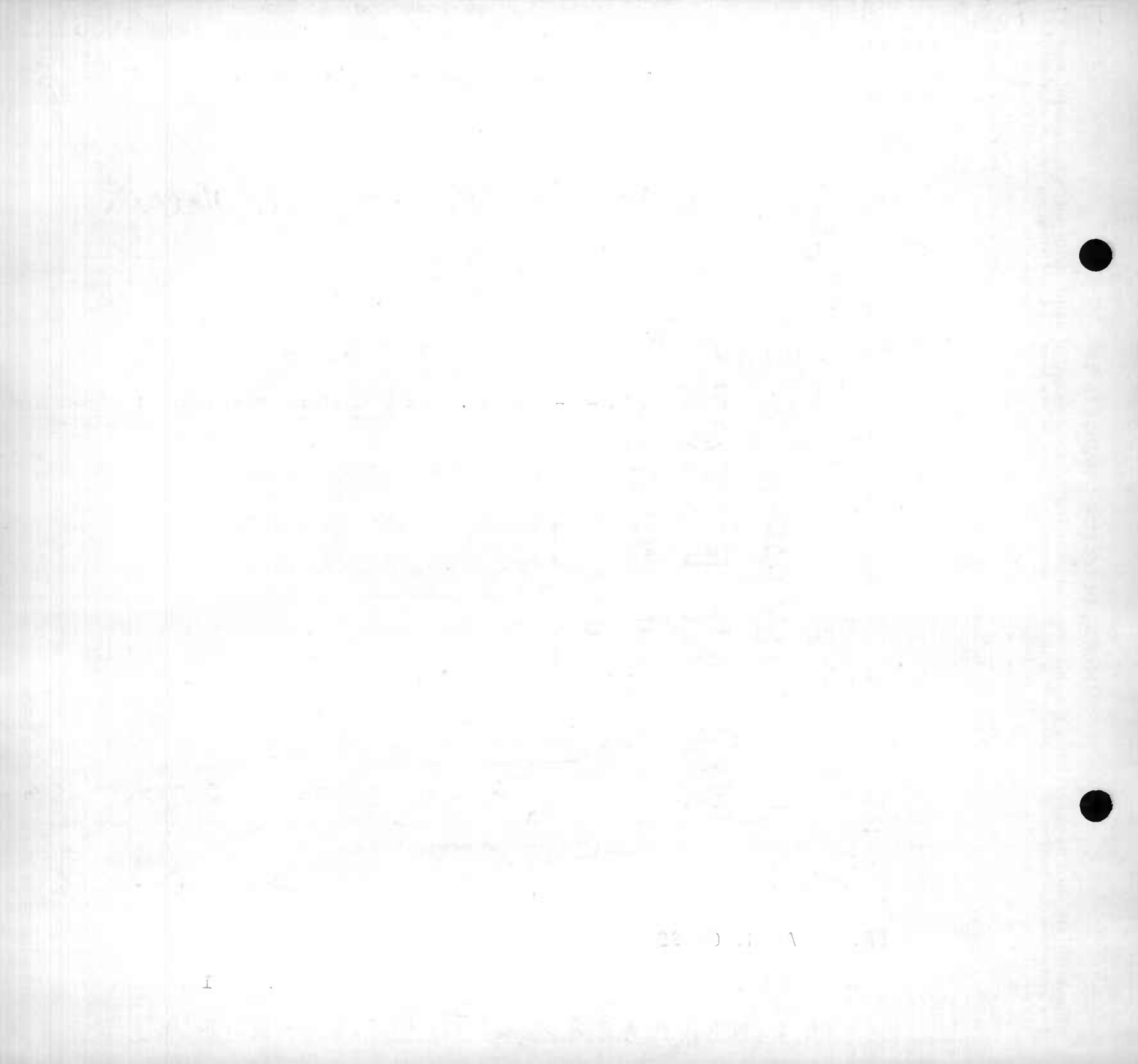
Baltimore City Health Department				Registered No. 66 06655	
BIRTH NO. 66 06655		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) AGNES K BRAUN		2. DATE AND HOUR OF DEATH 6-30-66 12:35A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY	
90 Bolton Hill Nursing Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Balto. 27-01	
		D. STREET ADDRESS (If rural, give location)		4604 Simms Ave.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-30-1901	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William J. Gibmeyer		14. MOTHER'S MAIDEN NAME Rose Eiler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-10-1781B		17. INFORMANT ADDRESS Mr. Frank C. Braun, 4604 Simms Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) cerebro-vascular accident DUE TO (B) thrombosis DUE TO (C) cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Parinonism		several yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1202 1965 to 6 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E Ellsworth Cook		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) E ELLSWORTH COOK		23D. ADDRESS M.D. 2431 MARYLAND AVE. BALTIMORE 21218 MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/66		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) Balto., Md.		(State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1966		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., Balto., Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

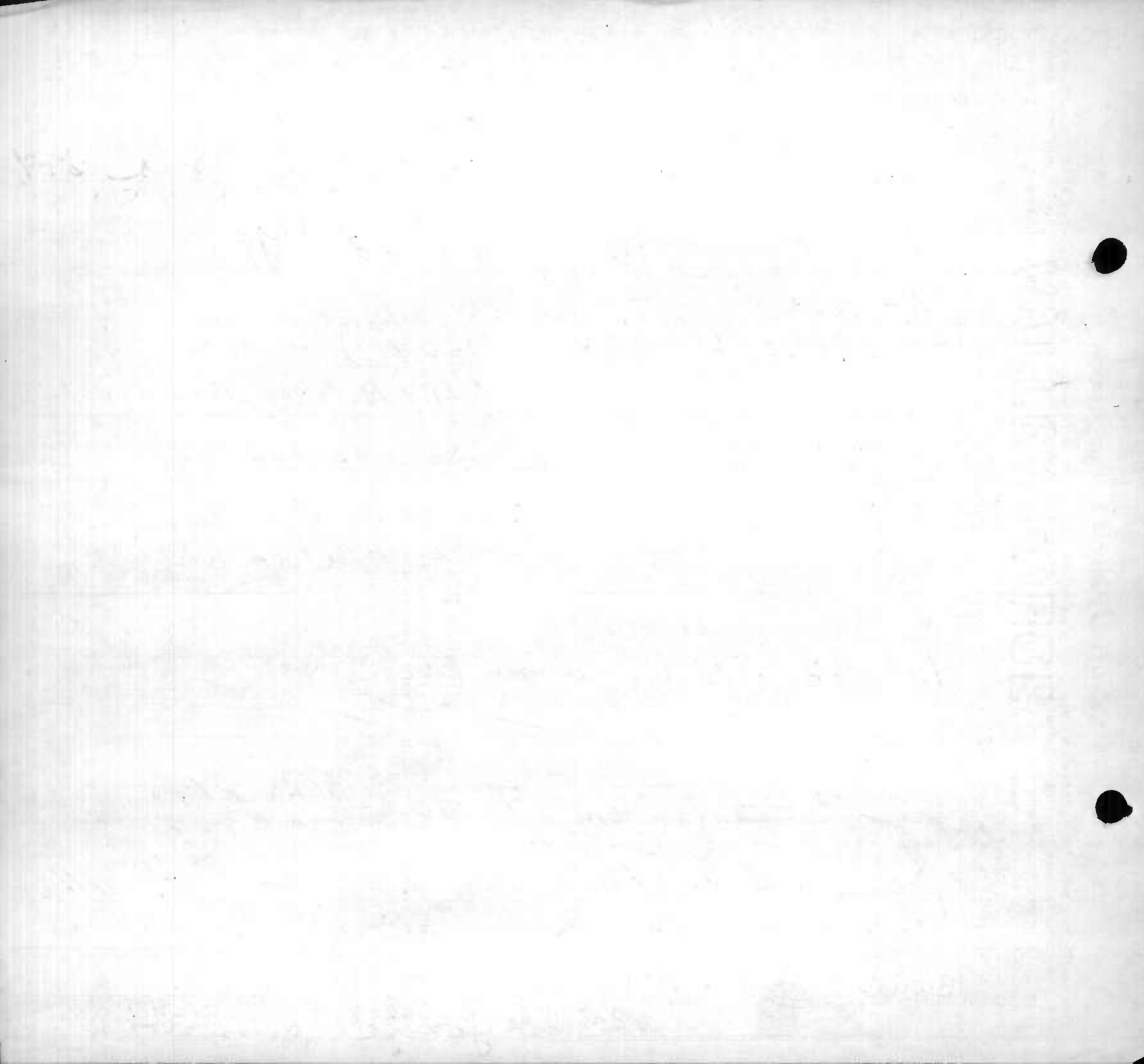
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06656	
BIRTH NO. 66 06656		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Thompson, Ruth Bailey		2. DATE AND HOUR OF DEATH 6-30-66 2:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 4430 Marble Hall Rd			
5. SEX F	6. RACE wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) wid	8. DATE OF BIRTH 4-16-95	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME NEHEMIAH BAILEY		14. MOTHER'S MAIDEN NAME ANNA AUGUSTA HOPPER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-03-8505		17. INFORMANT ADDRESS Mr. Robert Blizzard same address as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Coronary heart failure (B) Acute pulmonary edema (C) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) W		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-22-66 to 6-30-66, that (I) (we) last saw the deceased alive on 6-30-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. H. Gross		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-30-66	
23C. PHYSICIAN'S NAME (Type) DR. BRIAN H. GROSS		M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/2/1966	24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR JUL 1 1966 Robert E. Fickner	25C. FUNERAL DIRECTOR TICKNERS		ADDRESS - North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.		66 06657	
BIRTH NO.				66 06657			
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LINDSEY - Louis				2. DATE AND HOUR OF DEATH 6/25/66 4:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY			
5. SEX M				6. RACE N		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	
8. DATE OF BIRTH 10-24-88				9. AGE (In years, months, days) 77		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME THELBERT LINDSEY				14. MOTHER'S MAIDEN NAME SALLY JOHNSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MARY M. GRAY - 124 N. Poppleton St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. If means the disease, injury or complication which caused death.) 157X I				CAUSE OF DEATH (A) METASTATIC CA PANCREAS (B) BIATERAL PNEUMONIA (C) ATRIAL FIBRILLATION			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 6/17/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED obstructive jaundice		20A. AUTOPSY? (Yes or No) (NO)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/25/66 to 6/25/66 that (I) last saw the deceased alive on 6/25 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did did not view the body after death.							
23A. SIGNATURE Francisco M. Sanabria M.D.				23B. DATE SIGNED 6/25/66		23C. PHYSICIAN'S NAME (Type) Francisco M. Sanabria M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6-30-66		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION A.A. County Md.				25A. DATE REC'D BY HEALTH DEPT. JUL 1 1966			
25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR ADDRESS George V. Cooper - 512 N. Carrollton Ave. 2222 N. North			



1
G-620

66 06658

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 06658

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) VIRGINIA LEE GRACEY		2. DATE AND HOUR PRONOUNCED DEAD June 28, 1966 11:13 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 230 N. Monroe Street	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH May 6, 1911
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 55
13. FATHER'S NAME William Frooks		14. MOTHER'S MAIDEN NAME Leana Nelson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-30-3473	17. INFORMANT ADDRESS George Gracey 230 N. Monroe Street
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 6/26/66			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED uterine myoma & P.I.D.
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, lorn, factory, street, office bldg., etc.) hospital	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) FRANKLIN SQUARE HOSPITAL 19-02
21D. TIME OF INJURY (APPROX.) 6 ? 66 ?		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? therapeutic misadventure
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7/2/66	23C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery
24A. DATE REC'D BY HEALTH DEPT. JUL 1 1966		24B. NAME OF REGISTRAR Robert E. Farkas	24C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.
23D. LOCATION (City, town, or county) (State) Balto., Md.			

WALLEY FONGE

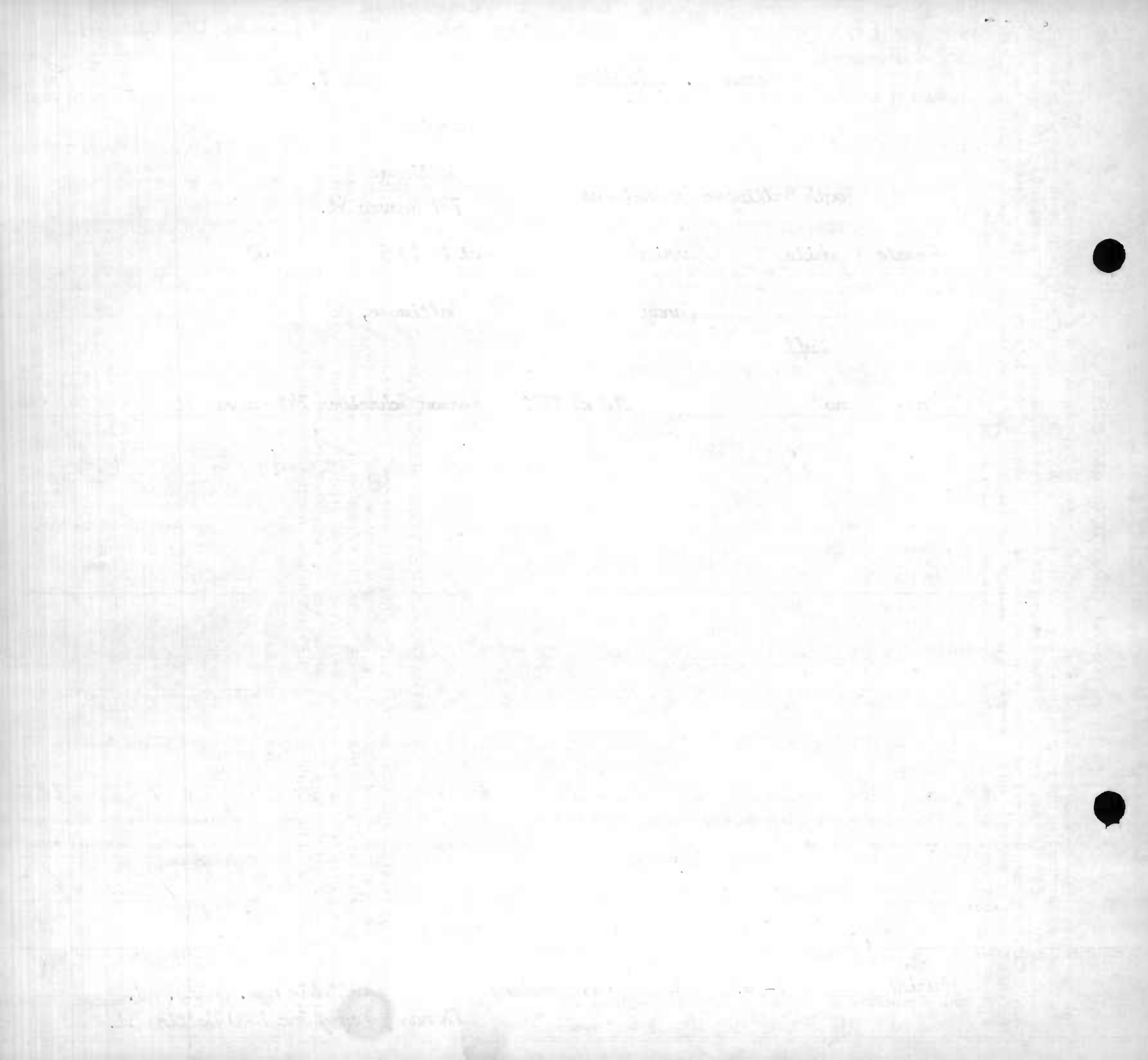
NO DOCUMENT

EX-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06659				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06659	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Sarah E. Schreiber				2. DATE AND HOUR OF DEATH July 1, 1966 12:30 PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 24-02	
South Baltimore General Hos				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 741 Harvey St.			
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct 19 1905	9. AGE (In years last birthday) 60	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Baltimore, Md
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY Candy		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Ruff				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212 28 1591		17. INFORMANT Herman Schreiber 741 Harvey St		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ante Coronary Thrombosis				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 day	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-1-1960 to 7-1-1966, that (I) (we) last saw the deceased alive on 7-1-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A.C. SOLLID				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-2-66	
23C. PHYSICIAN'S NAME (Type) A.C. SOLLID				23D. ADDRESS 707 Fort Ave -			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-66		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Hgh. Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Thomas J. Kenny Inc 1600 Hollins St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06660</u>	
BIRTH NO. <u>66 06660</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LELA YARRINGTON</u>		2. DATE AND HOUR OF DEATH <u>JULY 4 '66 3 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>FRANKLIN SQUARE HOSPITAL</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>19-04</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>1614 HOLLINS ST.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED</u> <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 1, 1903</u>	9. AGE (In years last birthday) <u>63 YRS</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA, U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS BOTTOMS</u>		14. MOTHER'S MAIDEN NAME <u>PHOEBE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Intracerebral hemorrhage</u> DUE TO (B) <u>Cerebrovascular accident</u> DUE TO (C) <u>Atherosclerotic cerebrovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 24</u> 19 <u>66</u> to <u>July 4</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 4</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour noted from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>B. Gabayani</u>				23B. DATE SIGNED <u>7/4/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. MAGGIO</u>		23D. ADDRESS <u>FRANKLIN SQ. HOSPITAL, BALTIMORE MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-6-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Richmond, Va</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Thomas J. Kenny Inc</u>		25D. ADDRESS <u>1600 Hollins Balto Md</u>	

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C-653

66 06651

BALTIMORE CITY HEALTH DEPARTMENT

66 06651

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)~~Adeline X CRANDALL~~ ADELAIDE G. CRANDALL

2. DATE AND HOUR PRONOUNCED DEAD

June 28, 1966

5:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

B. COUNTY

Maryland

Balto

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4305 Ridge Drive

21229

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9-11-1909

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

ALBERT TOWNSEND

14. MOTHER'S MAIDEN NAME

GREEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

MR. CHARLES A. CRANDALL, 4305 RIDGE DRIVE #29

18. E 929.2
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Drowning

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

water

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Campbell's Quarry

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 28 66 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

undetermined-found in water

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 29, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7-1-66

23C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL CEMETERY

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

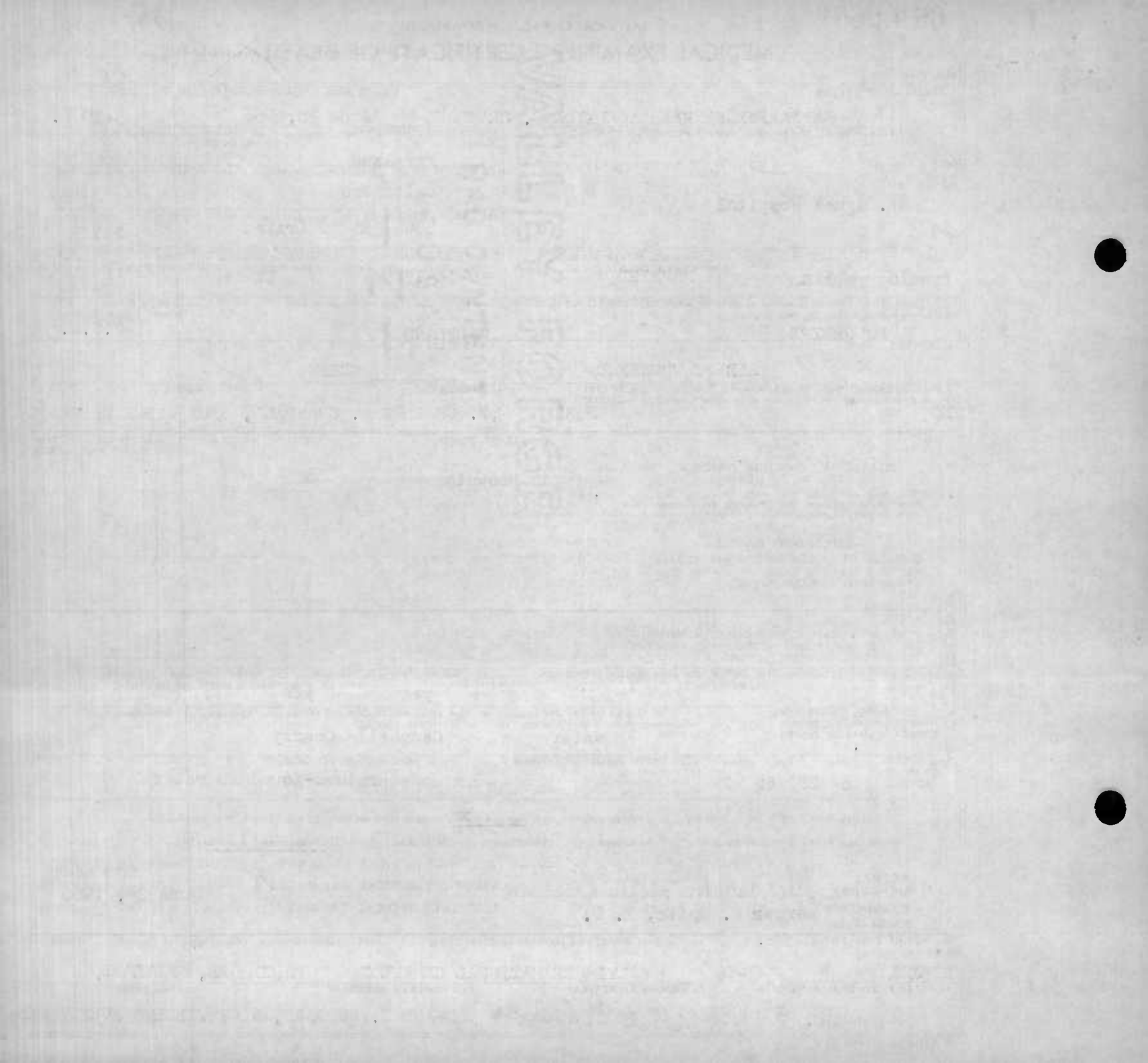
24C. FUNERAL DIRECTOR

ADDRESS

JUL 5 1966

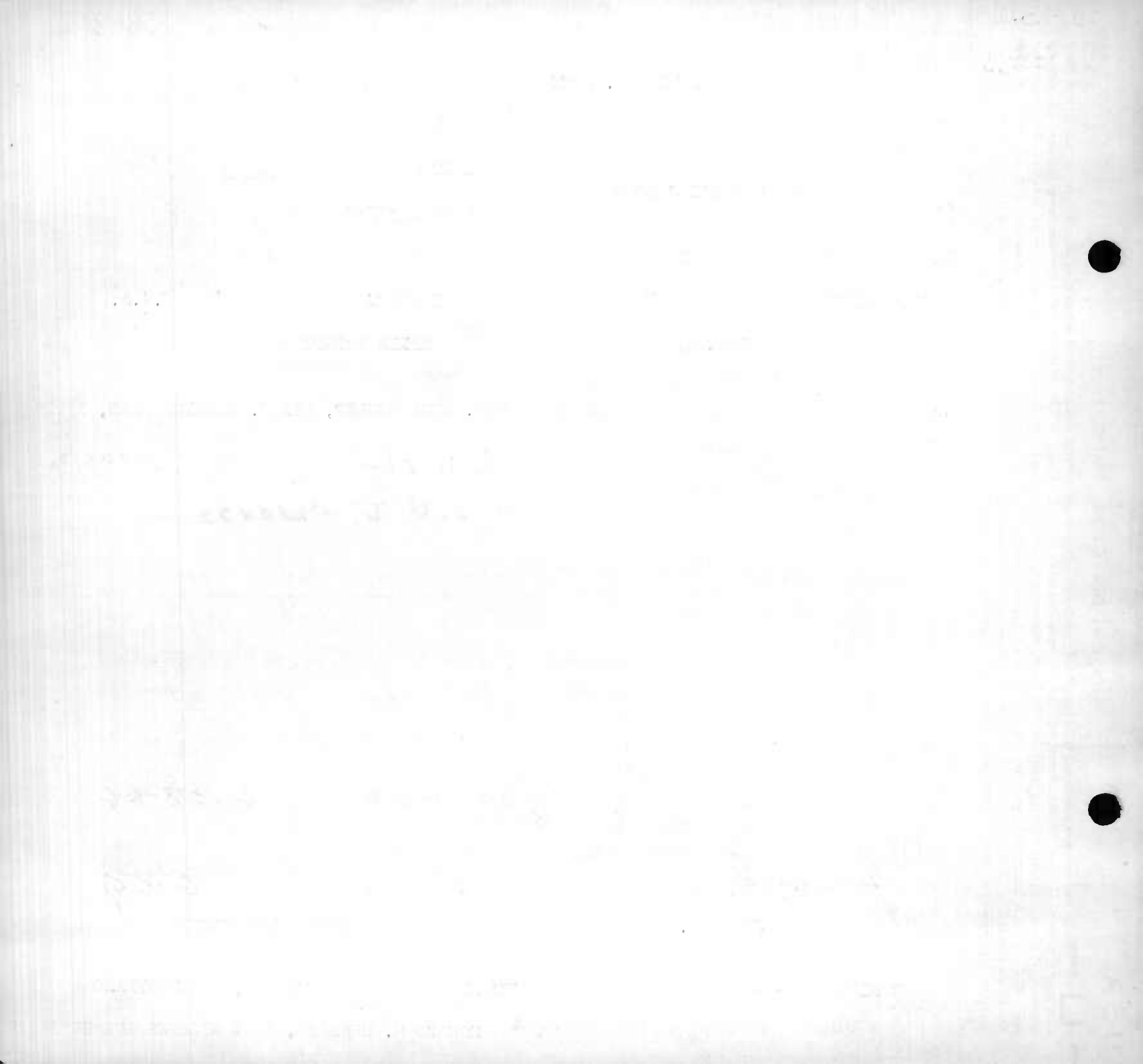
Robert E. Farley, M.D.

HOWARD H. HUBBARD, 5107 WILKENS AVENUE #29



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06662	
BIRTH NO. 66 06662		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ALVINA M. JETT		2. DATE AND HOUR OF DEATH JUNE 28, 1966 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HOOD NURSING HOME		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) HOOD NURSING HOME			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3-25-1870	9. AGE (In years last birthday) 96	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MINNESOTA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME MARIE VOIGHT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. ANNA ENGLER, 815 S. WARWICK ROAD, 21229	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) DUE TO C.I.A. (B) DUE TO C.I.S.C. V. NARCOSES (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-1-65 19 to 6-28-66 19, that (I) (we) last saw the deceased alive on 6-28-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James G. Howell</i> M.D.				23B. DATE SIGNED 6-29	
23C. PHYSICIAN'S NAME (Type) JAMES G. HOWELL		23D. ADDRESS 1011 FREDERICK AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-1-66		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229	



Classified by Medical Examiner (Surrogate)
As Prescribed

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06663	
BIRTH NO. 66 06663		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY GERTRUDE PFEIFFER [REDACTED]		2. DATE AND HOUR OF DEATH 6/29/66 9:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND			
HOUSE IN THE PINES 5837 BELAIR ROAD		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 20-03			
D. STREET ADDRESS (If rural, give location) FORMERLY OF 2019 RAMSEY STREET					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH X 8-27-83	9. AGE (In years last birthday) 82	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH A. MURPHY		14. MOTHER'S MAIDEN NAME MARY CLARK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS MR. ALBERT J. PUESCHEL, 3401 RAVENWOOD AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO (B) Atherosclerotic Heart Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4(+) years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Chronic Bronchitis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Jan 14 1966 to Jan 19 1966, that (I) (we) last saw the deceased alive on Jan 14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE/SIGNED 6/29/66	
23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY		23D. ADDRESS M.D. 4900 BELAIR RD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-2-66		24C. NAME of CEMETERY or CREMATORY LOUDON PARK CEMETERY	
24D. LOCATION BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD 4107 WILKENS AVE.	

1958

That person who
intended to be

the book

1958

6/25/58

1958

L-5125

66 06664

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 06664

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD W. LANGSCHMIDT

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1966

12:32 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

RELAY

D. STREET ADDRESS (If rural, give location)

5007 Hazel Avenue

21227

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

2-10-1895

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED ACCOUNTANT

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

FREDERICK WM. LANGSCHMIDT

14. MOTHER'S MAIDEN NAME

SOPHIE KAUFMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.
212-07-9857

17. INFORMANT

ADDRESS

MR. EDWARD GREASON LANGSCHMIDT, SAME AS 4D

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/30/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7-2-66

23C. NAME of CEMETERY or CREMATORY

LOUDON PARK CEMETERY

23D. LOCATION

BALTIMORE,

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

JUL 5 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

HOWARD H. HUBBARD, 4107 WILKENS AVENUE #29

WALLACE HONGE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM L WEBER

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1966 3:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF DECEASED
INSTITUTION

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

805 W. 38th Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Sept. 24, 1918

9. AGE (In years
last birthday)

47

10. Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MAINTENANCE MAN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

YES

WWII

16. SOCIAL
SECURITY NO.

21376-4833

17. INFORMANT

ADDRESS

Dorothy L. Weber

805 W 38th St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/30/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-2-66

23C. NAME of CEMETERY or CREMATORY

Lorraine Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 5 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Paul E. Chenoweth, Inc.

ADDRESS

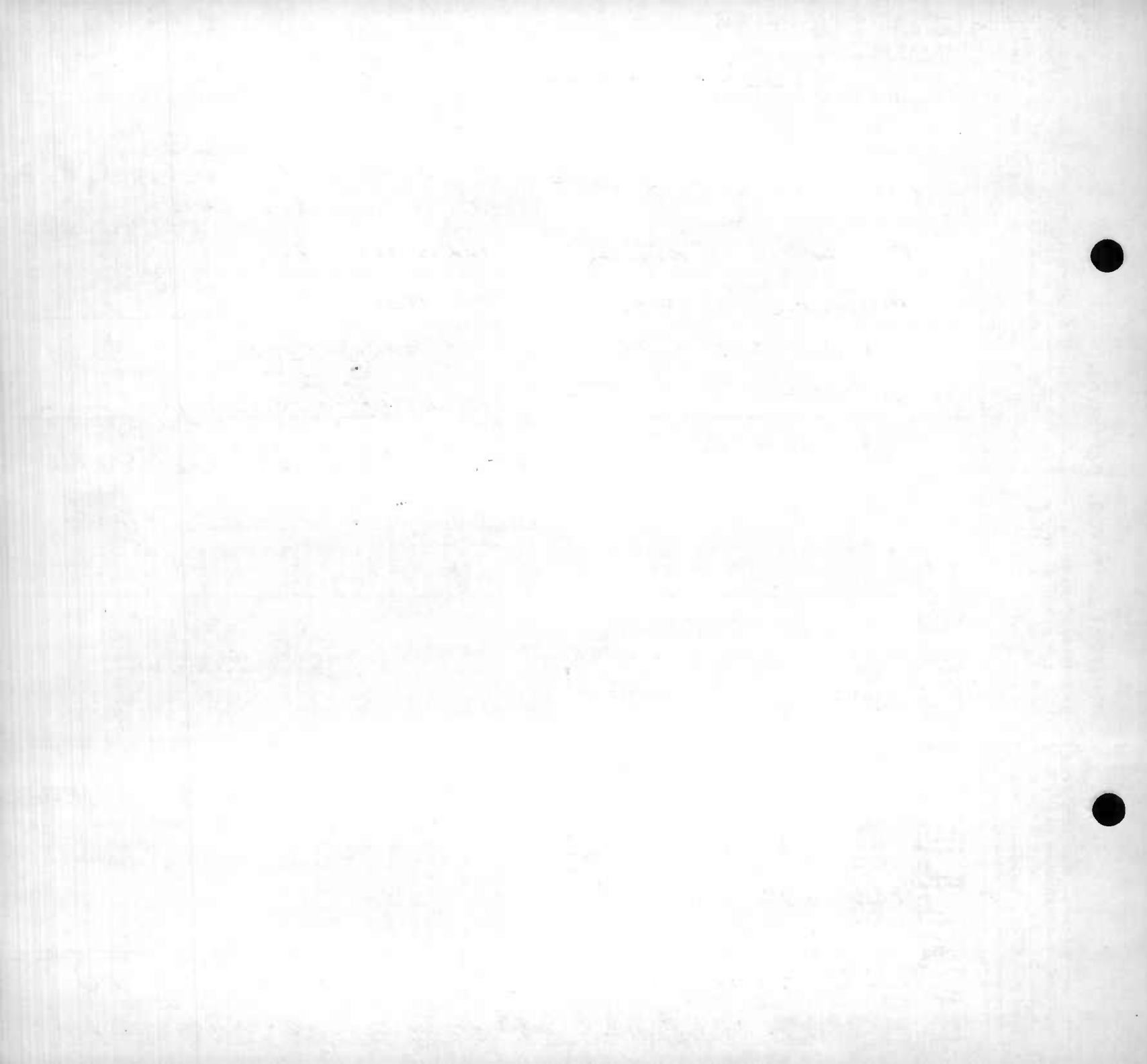
3615-17-19 Chestnut and 2121

Appt/record for William Louis "eber- born 9/24/18 at Mt.Washington.Md. & babp.11/24/18 at
Mt.Washington M.E.Church

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 06666	
BIRTH NO. 66 06666		CERTIFICATE OF DEATH		M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LENA BRILLHART		2. DATE AND HOUR OF DEATH JUNE 29, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 501 S. CHAPELGATE LANE		A. STATE MD. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 28-04 D. STREET ADDRESS (If rural, give location) 501 S. CHAPELGATE LANE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH JAN 17, 1881	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME CHARLES OETTINGER			
14. MOTHER'S MAIDEN NAME MARY BETZ		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mari Betz - 501 S. Chapelgate Lane			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) DUE TO General Hypertensive Pneumonia (B) DUE TO Hypertensive Cardio-Vascular Senile (C)		INTERVAL BETWEEN ONSET AND DEATH 8 days 6 years	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-19-1957 to 6-29-1966 that (I) (we) last saw the deceased alive on 6-28-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. J. Johnson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-2-66		24C. NAME of CEMETERY or CREMATORY Landon Park Cem.	
24D. LOCATION (City, town, or county) (State) Balt. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Taylor & Son			
25D. ADDRESS 11400 Coltonville Trl					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 06667					CERTIFICATE OF DEATH					Registered No. 66 06667									
1. NAME OF DECEASED (Type or Print) <i>A. Loretta Connor</i>										2. DATE AND HOUR OF DEATH <i>6-28-66 10.05 P.M.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>BON SECOURS Hospital</i> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>CATONSVILLE</i> D. STREET ADDRESS (If rural, give location) <i>13 South Beaumont Ave.</i>									
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>Oct. 24, 1891</i>		9. AGE (In years last birthday) <i>74</i>		If Under 1 Yr. Months: Days: Hours: Min.									
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEKEEPER</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>HOUSE</i>					11. BIRTHPLACE (State or foreign country) <i>BALTO.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Charles M. Mc Cabe</i>										14. MOTHER'S MAIDEN NAME <i>Ellen M. McIntyre</i>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>					16. SOCIAL SECURITY NO. <i>—</i>					17. INFORMANT <i>Paul Connor - Brother</i>					ADDRESS				
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) <i>AORTIC STENOSIS</i> DUE TO (B) <i>CORONARY ARTERIOSECLEROSIS</i> DUE TO (C) <i>ASCVD.</i>					INTERVAL BETWEEN ONSET AND DEATH <i>YEARS</i> <i>YEARS</i> <i>YEARS</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <i>MAY 30 1966</i> to <i>JUNE 28 1966</i> , that (I) (we) last saw the deceased alive on <i>JUNE 28 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <i>Agustin del Campo</i> M.D.										Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <i>JUNE 28 1966</i>				
23C. PHYSICIAN'S NAME (Type) <i>AGUSTIN del CAMPO</i> M.D.										23D. ADDRESS <i>BON SECOURS Hosp. BALTO. MD</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>7-2-66</i>					24C. NAME of CEMETERY or CREMATORY <i>Catholic Cem.</i>					24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1966</i>					25B. NAME OF REGISTRAR <i>Robert E. Farley</i>					25C. FUNERAL DIRECTOR <i>Farley-Cronough & Co. Catonsville, Md.</i>					ADDRESS				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 06668					CERTIFICATE OF DEATH		Registered No. 66 06668		
1. NAME OF DECEASED (Type or Print) EFFORD, GEORGIANA M					2. DATE AND HOUR OF DEATH 6/28/66 11:05 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #28 53-00 D. STREET ADDRESS (If rural, give location) 11 OSBORNE AVE.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 1/28/88	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME HENRY DON A#80					14. MOTHER'S MAIDEN NAME WALTERS, AMANDA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 217054978		17. INFORMANT ADDRESS ST. AGNES RECORDS WILKENS & CATON				
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH approx 1 wks.									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASC U+D, congestive heart failure, compensated Glaucoma									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JUNE 27 19 66 to JUNE 28 19 66 , that (I) (we) last saw the deceased alive on JUNE 28 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>M. Peter Stasiowski</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 6-29-66				
23C. PHYSICIAN'S NAME (Type) M. PETER STASIOSKI					23D. ADDRESS ST. AGNES HOSPITAL - CATON & WILKENS				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-66		24C. NAME OF CEMETERY or CREMATORY Parkwood Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Henry Cunningham		25D. ADDRESS P.O. Box 6601, Baltimore, Md.			

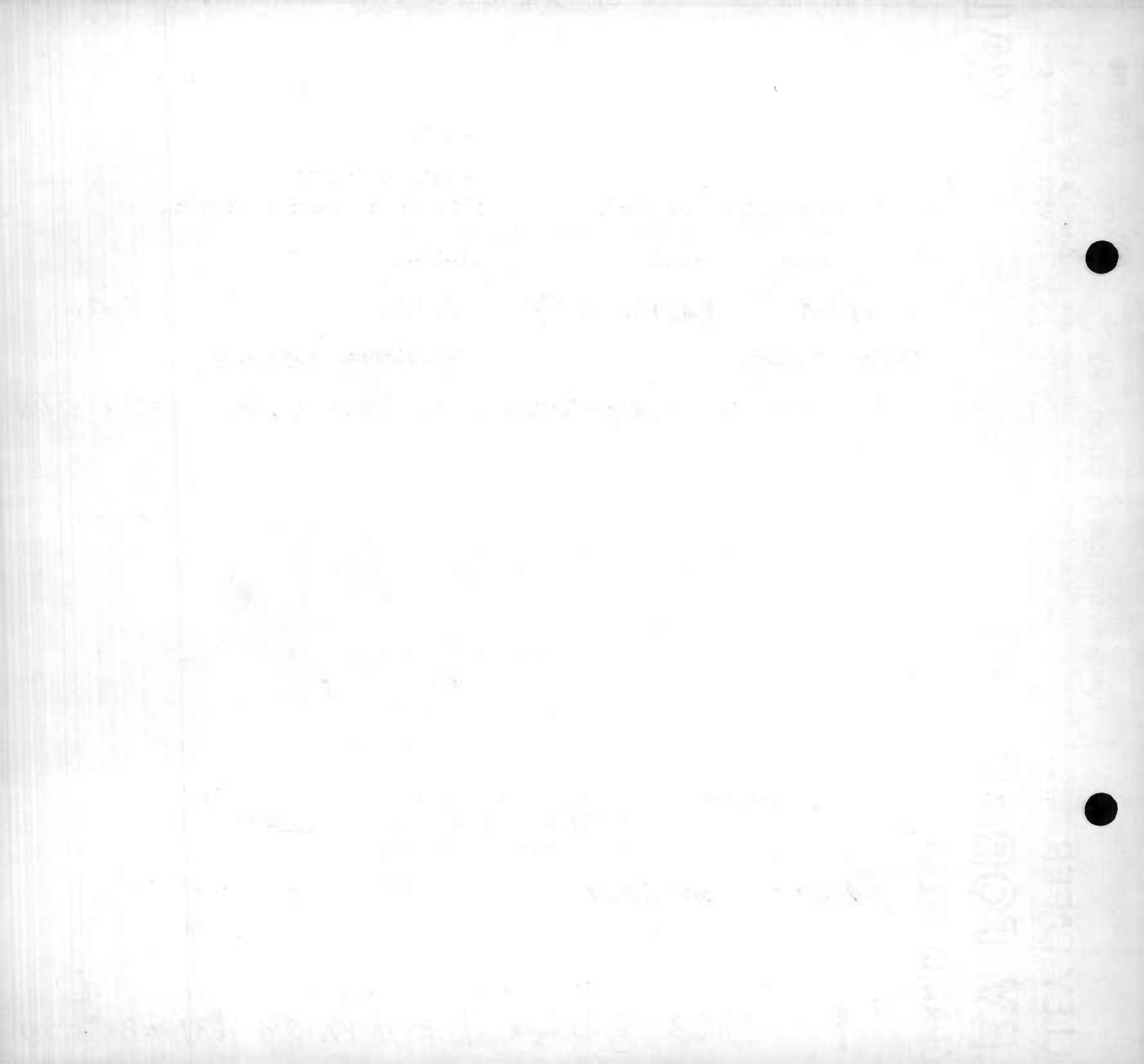
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 06669</u>	
BIRTH NO. <u>66 06669</u>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>Edward Johnson</u>				2. DATE AND HOUR OF DEATH <u>11:50am 6/30/66</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 The Johns Hopkins Hospital</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21213</u>		D. STREET ADDRESS (If rural, give location) <u>2731 East Preston Street</u>	
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>11-15-15</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JAINTOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BAKTO. CITY</u>		11. BIRTHPLACE (State or foreign country) <u>IND.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Georgianna JOHNSON</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WAR 2</u>				16. SOCIAL SECURITY NO. <u>214-03-4686</u>		17. INFORMANT ADDRESS <u>SARAH JOHNSON 2731 N. E. PRESTON</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>MASSIVE INTRACEREBRAL BLEED</u>				CAUSE OF DEATH (A) <u>hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6h</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>many years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>JOHN ROBINHOLD</u> attended the deceased from <u>6/30</u> 19 <u>66</u> to <u>6/30/66</u> 19 <u>66</u> and that (I) <u>JOHN</u> last saw the deceased alive on <u>6/30/66</u> 19 <u>66</u> and that in (my) <u>JOHN</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>JOHN</u> (did) <u>not</u> view the body after death.							
23A. SIGNATURE <u>Daniel G. Robinhold</u>						23B. DATE SIGNED <u>6/30/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Daniel G Robinhold</u>						23D. ADDRESS M.D. <u>JHH</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-6-66</u>		24C. NAME of CEMETERY or CREMATORY <u>BALTIMORE NATIONAL</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>JOSEPH KNIGHT 1639 N. BROADWAY</u>			



1
S-423

66 06670

BALTIMORE CITY HEALTH DEPARTMENT

66 06670

BIRTH NO. 65-17014 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Allen SLAUGHTER				2. DATE AND HOUR PRONOUNCED DEAD June 30, 1966 7:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33/14 Johns Hopkins Hospital (DOA)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-05 D. STREET ADDRESS (If rural, give location) 1833 N. Washington Street			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH July 9, 1965	9. AGE (in years last birthday) 11 mths.	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oliver Slaughter				14. MOTHER'S MAIDEN NAME Clyding Bell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS LESSIE SLAUGHTER 1908 E. LAFAVETTE			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 391.21 Dehydration Otitis media, purulent, Bilateral				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED July 1, 1966 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 7-5-66	23C. NAME OF CEMETERY or CREMATORY MT-CALVARY		23D. LOCATION (City, town, or county) (State) A.A. COUNTY MD		
24A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		24B. NAME OF REGISTRAR P. E. Farley		24C. FUNERAL DIRECTOR ADDRESS JOSEPH KNIGHT 1639 N. BROADWAY			

WALTER FOREST

1
W-452

66 06671

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 62-03738 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 06671

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MICHAEL WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1966

7:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2211 Aiken Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

3-13-62

9. AGE (In years
last birthday)

4

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

CARTER WILLIAM

14. MOTHER'S MAIDEN NAME

DORIS WALKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

LAURA WRIGHT 2211 AIKEN ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Acute sickle cell crisis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-29-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7-2-66

23C. NAME of CEMETERY or CREMATORY

MT CALVARY

23D. LOCATION (City, town, or county) (State)

A.A. COUNTY Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JOSEPH KNIGHT 1639 N BROADWAY

WALTER DORGE

DOCUMENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06672		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06672	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Owens, John LEE		2. DATE AND HOUR OF DEATH 4 July 1966 12:20 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Md. Hosp		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto 16-07			
D. STREET ADDRESS (If rural, give location) 1109 Dukeland 16 St					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12 Sept 1918	9. AGE (In years lost birth) 47	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Balto Public Schools Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Owens		14. MOTHER'S MAIDEN NAME Lucy Eason			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 223 22-6437		17. INFORMANT Wife Rose Lee	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Ca. lung		CAUSE OF DEATH (A) DUE TO Metastatic disease (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3 July 1966 to 4 July 1966, that (I) (we) last saw the deceased alive on 4 July 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE DeLanfor, C.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4 July 1966	
23C. PHYSICIAN'S NAME (Type) DeLanfor, C.D.		23D. ADDRESS University Hosp.			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/66		24C. NAME OF CEMETERY or CREMATORY BALTO NATIONAL	
24D. LOCATION BALTO MD					
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Manshan P. Nym 638 N. Gilemor St	

B-622

66 06673

BALTIMORE CITY HEALTH DEPARTMENT

66 06673

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WALTER BURGESS

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1966

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

903 W. Saratoga Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

903 W. Saratoga Street, Apt. 6

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9. AGE (In years
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Burgess

14. MOTHER'S MAIDEN NAME

Rachet

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

BERTHA HAYNES 903 W. Saratoga St

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-1-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

7/3/66

23C. NAME of CEMETERY or CREMATORY

Mt Airy

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 5 1966

Robert E. Finkbeiner

Thomas P. Hayes 68 N. Guilford

WALTER D. POPE

1
S-530

66 06674

BALTIMORE CITY HEALTH DEPARTMENT

66 06674

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

ESSIE LEROY SMITH

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1966 2:45 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1326 Bond Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Nov. 30, 1934

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Elisha Smith

14. MOTHER'S MAIDEN NAME

Sylvira Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

216-32-8173 Mr. Ivanhoe Smith 1720 Homestead St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stab Wound of Chest.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Front of 1336 N. Bond Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 24 '66 P

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed in chest.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/30/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/3/66

23C. NAME of CEMETERY or CREMATORY

Tyre River, Virginia

23D. LOCATION

(City, town, or county)

Tyre River, Virginia

(State)

24A. DATE REC'D BY HEALTH DEPT.

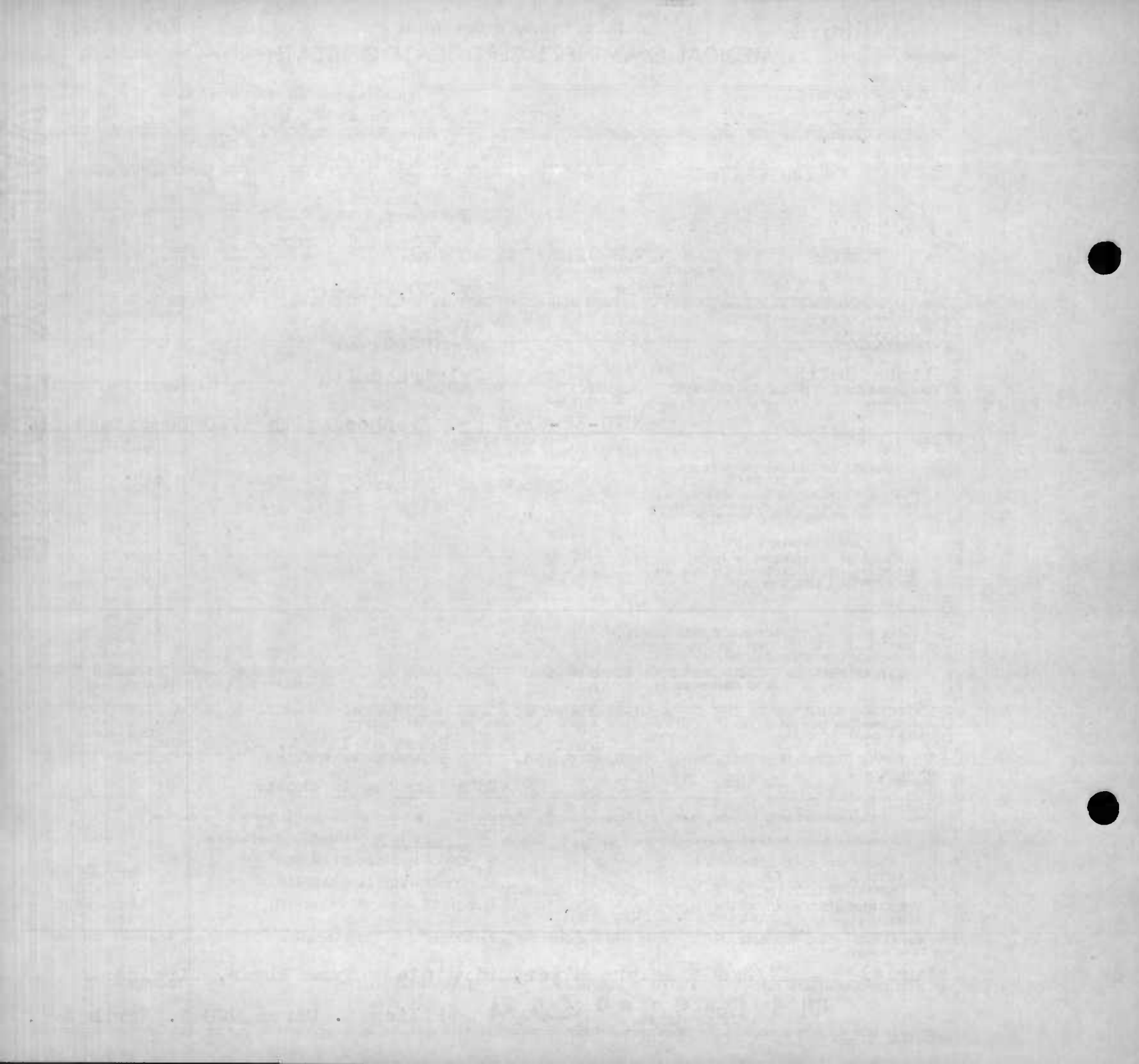
JUL 5 1966

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

William C. March 928 E. North Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06675				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06675	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) Cornelius Dewey						6/29/66 825am 825 a M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
Johns Hopkins Hospital				Md. Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore		9-09	
				D. STREET ADDRESS (If rural, give location)			
				1016 E. Preston St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days Hours Min.		If Under 24 Hrs. Min.
M	N	Single	2/10/99	67			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
LABORER		GENERAL		CATAWBA, N.C.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Alexander Cornelius				Emma Rawls			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				219-01-6668		WALDEN T. FARRER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) UNKNOWN - ? myocardial infarction			
ANTECEDENT CAUSES				(B) ECG -			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
6-27-66		Herniated lumbar discs -		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from June 22 19 66a June 28 19 66, that (I) (we) last saw the deceased alive on June 29 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Brian D. Lowery MD						6-29-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Brian D. Lowery				M.D. The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		6/3/66		Motts Grove		CATAWBA COUNTY, N.C.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUL 5 1966		Robert E. Taylor, Jr.		R. J. REYNOLDS NEWTON, N.C.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

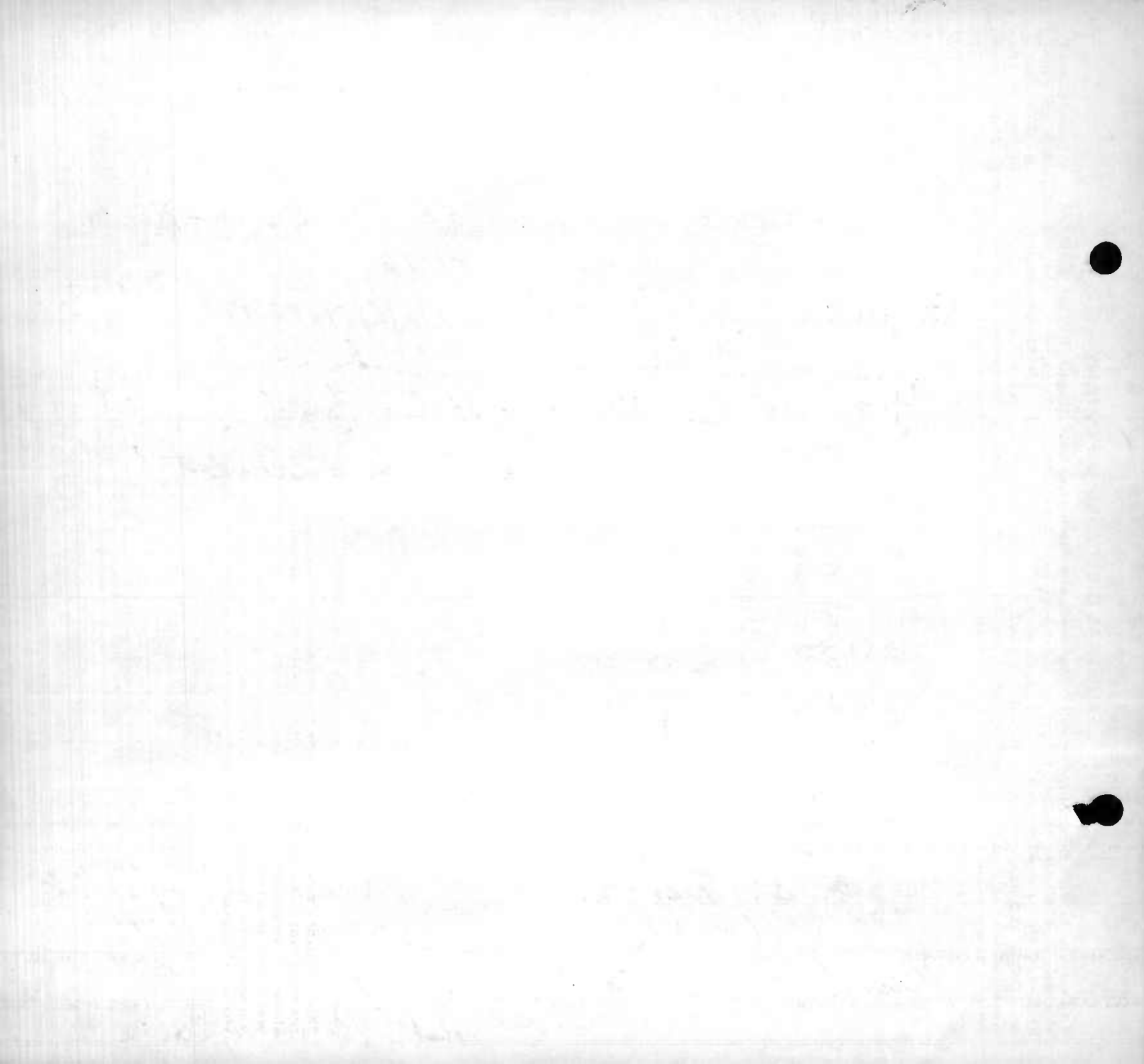
BIRTH NO. 66 06676				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06676	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Pattie Mae Jones				2. DATE AND HOUR OF DEATH June 29, 1966 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 820 Woodington Road Baltimore, Maryland				A. STATE Maryland B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 820 Woodington Road			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH April 22, 1913	9. AGE (In years last birthday) 53 years	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chapel Hill N.C.		12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Richard Jones			14. MOTHER'S MAIDEN NAME Pearl Hunt				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. UNK		17. INFORMANT Richard Jones Jr.		ADDRESS 820 Woodington Rd.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 153.5 I			CAUSE OF DEATH Carcinoma of colon UNKNOWN			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Gastric Ulcers UNKNOWN (C) Epilepsy Lifetime							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1963 to June 29, 1966 , that (I) was last saw the deceased alive on April 15, 1966 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.							
23A. SIGNATURE William H. Watts				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-30-66	
23C. PHYSICIAN'S NAME (Type) William H. Watts				23D. ADDRESS 715 Woodington Ave Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE JUL 5 1966		24C. NAME of CEMETERY or CREMATORY Abraham Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Donald E. Glover		ADDRESS 1701 N. Patterson Pk.	

Handwritten text, possibly a signature or date, located in the upper right quadrant of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be a, proved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06677		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06677	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Edward A. Bush			
2. DATE AND HOUR OF DEATH 6-29-66 12:01 A.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp.		(If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21271 53-00	
D. STREET ADDRESS (If rural, give location) 5B. Westway - North.		5. SEX M. 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 1-1-16 9. AGE (In years last birthday) 50		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Bldg Carpenter		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unhu		14. MOTHER'S MAIDEN NAME Unhu		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 414030799	
17. INFORMANT Pathie Bush		ADDRESS above		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Cerebral Vascular Accident	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 6-29-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from 6-28-66 to 6-29-66, that (we) last saw the deceased alive on 6-29-66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Calvin E. Jones, Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/29/66		23C. PHYSICIAN'S NAME (Type) Calvin E. Jones, Jr.	
23D. ADDRESS South Baltimore General Hosp.		24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7-2-66		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Balto Md		25A. DATE REC'D BY HEALTH DEPT 6-29-66		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Robert S. Baranco, Severna Park, Md.	
ADDRESS							



FUNERAL DIRECTOR: IMPORTANT

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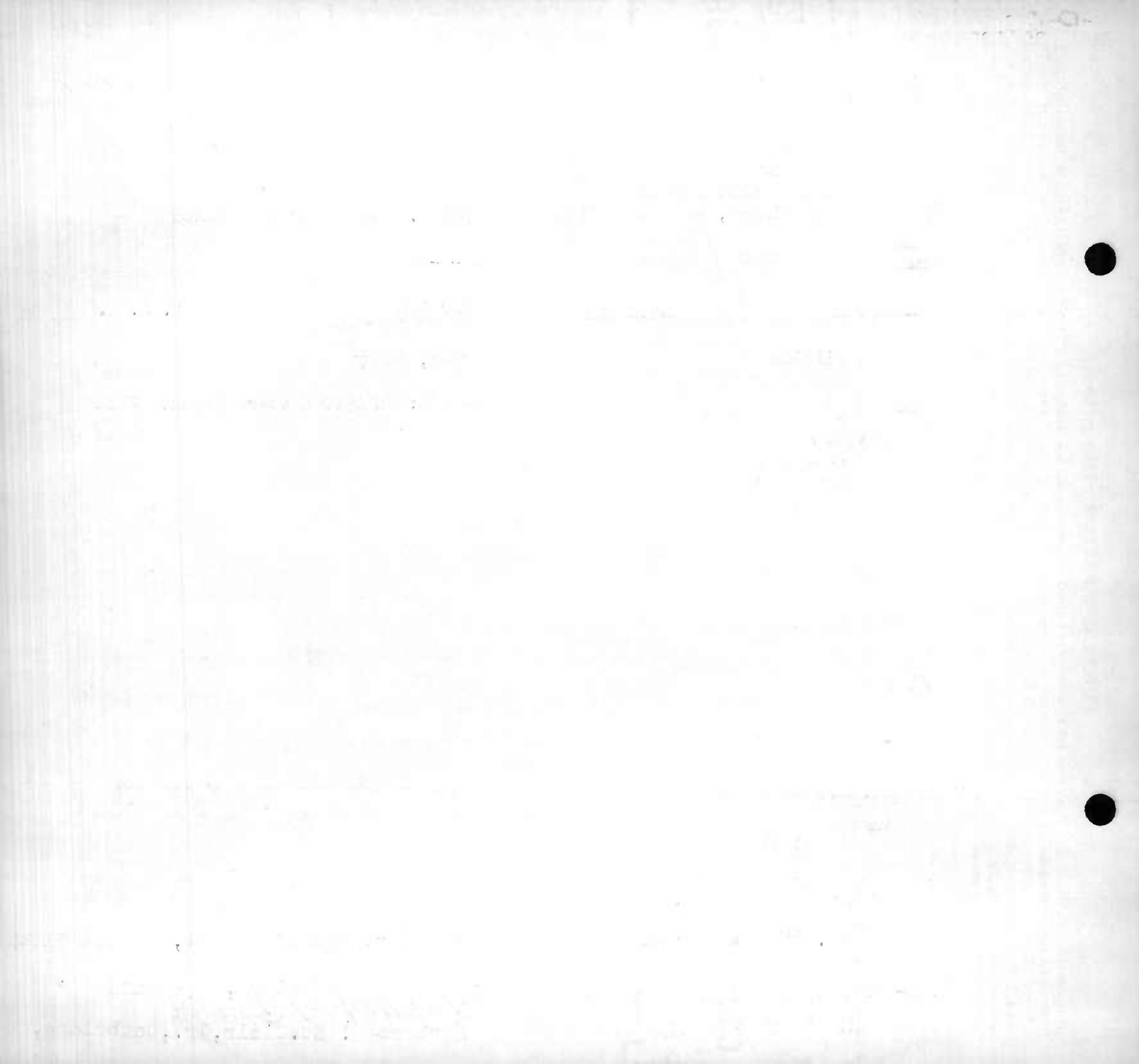
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06678	
BIRTH NO. 66 06678				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) IRETON, Blanche				June 29, 1966 10:10 A.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND	
JENKINS MEMORIAL HOSPITAL		1000 S. Caton Ave.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Baltimore, Md. 21229		Baltimore 21218		D. STREET ADDRESS (If rural, give location)	
71		731 E. 20th St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W	Widowed	7-31-81	85 yrs.	U S A
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Baltimore, Md	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Lawrence Wolfe			Annie Wolfe Ryan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		No		Medical Records Room	
18. 493 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH	
				Pneumonia	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH	
				2 1/2 hrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
generalized cerebral artery disease					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (H) (this hospital) attended the deceased from 6/29 1966 to 6/29 1966 and that (H) (we) last saw the deceased alive on 6/29 1966 and that (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. Raymond Gladue				6/29/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J RAYMOND GLADUE				JENKINS MEMORIAL-1000 S Caton Ave. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		7/1/66		CATHEDRAL CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 5 1966		Robert E. Jackson		Mitchell-Wiedefeld Home, Inc.	
				6500 York Road-21212	

36-21-21
FR

FUNERAL DIRECTOR: IMPORTANT

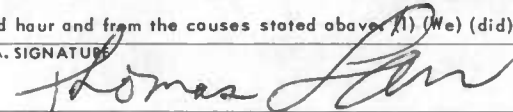
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

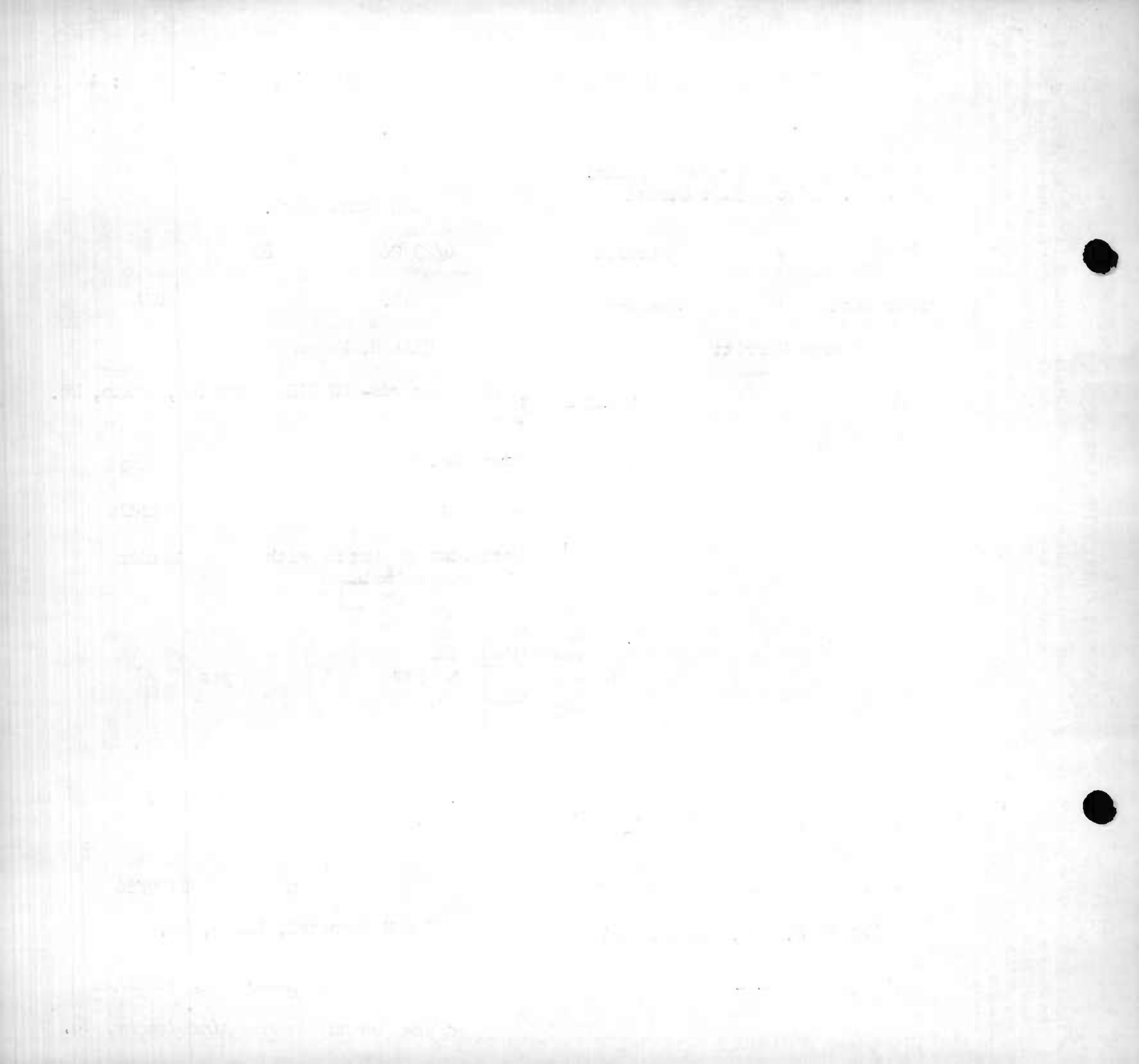
BIRTH NO. 66 06679				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06679	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Alpha Proctor</u>				2. DATE AND HOUR OF DEATH <u>6/30/66</u> <u>1245P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				A. STATE <u>Maryland</u> B. COUNTY <u>703</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				D. STREET ADDRESS (If rural, give location) <u>504 N. Dumcan Street 21205</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Separated</u>	8. DATE OF BIRTH <u>10-2-1885</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Nichols William</u>				14. MOTHER'S MAIDEN NAME <u>Green, Jenny</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>RECORDS: BCH 4940 Eastern Avenue 21224</u>		
18. <u>422.1 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CHF</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10/26/65</u> 19 to <u>6/30/66</u> 19 that (I) (we) first saw the deceased alive on <u>6/30/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Wm. Emerson</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>6/30/66</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. William Emerson</u>				23D. ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Rem-Burial</u>		24B. DATE <u>7/7/1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Bethel Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>Herbert M. St. Clair, Jr.</u> ADDRESS <u>Cambridge, Md</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06680		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06680	
M.E. CASE NO.		CERTIFICATE OF DEATH		June 29, 1966 3:40 A.M.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HOWARD SAMPSON MERRITT					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street		A. STATE		B. COUNTY	
		Va.		1-43	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Chincoteague			
		D. STREET ADDRESS (If rural, give location)			
		104 Ocean Blvd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
M	W	Married	6/23/06	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
owner boat		Seafarer		Va.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George Merritt		Ella N. Mason		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		230-42-5293		Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO		Days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Bronchopneumonia			
		(B) DUE TO		Months	
		Cachexia			
		(C) DUE TO		Months	
		Carcinoma of larynx with multiple metastases			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Apr. 19 1966 to June 29 1966, that (I) (we) last saw the deceased alive on June 29 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D.		23B. DATE SIGNED	
				6/29/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Thomas J. Lau, Surgeon (R)		US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7-2-66		John Taylor Cemetery	
25A. DATE RECEIVED		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 5 1966		Robert E. Salyer		Salyer Funeral Home Chincoteague, Va.	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Temperanceville, Virginia					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06681				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06681	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Anna A. Deller				2. DATE AND HOUR OF DEATH June 29, 1966 10:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Windsor Rest Home 3025 Windsor Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1760 Park Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 9/21/72	9. AGE (In years last birthday) 93	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Andrew Collison				
14. MOTHER'S MAIDEN NAME Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. None			17. INFORMANT Miss C. Viola Carmine-1702 Eutaw Pl.				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction DUE TO (B) Generalized Arteriosclerosis DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 6/29/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/18/64 19 to 6/29/66 19, that (I) (we) last saw the deceased alive on 6/29/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Hollis Seunarine</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED June 30, 1966			
23C. PHYSICIAN'S NAME (Type) Hollis Seunarine		23D. ADDRESS M.D. 930 Whitelock Street,					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE JUL 27/2/66		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. 1966		25B. NAME OF REGISTRAR Robert C. Altenburg		25C. FUNERAL DIRECTOR ADDRESS Robert C. Altenburg 6009 Harford Road Funeral Home Inc. Baltimore, Md. 21214			

10/10/10 10/10/10 10/10/10

Bill and all

47-05-68
JJ

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06682		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06682	
M.E. CASE NO.		CERTIFICATE OF DEATH		1. NAME OF DECEASED	
1. NAME OF DECEASED (Type or Print)		CORNELIA PEARL BARNES		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		June 29, 1966 1:40 P.M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
BALTIMORE CITY HOSPITALS		MARYLAND		Baltimore	
4940 EASTERN AVENUE		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE COUNTY 21221	
BALTIMORE, MARYLAND 21224		D. STREET ADDRESS (If rural, give location)		1627 GAIL ROAD	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	WHITE	MARRIED	10-20-98	67	Housewife
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
North Carolina		U.S.A.		John Underwood	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Amelia Hinton		NO		215 14 5906B	
17. INFORMANT		18. CAUSE OF DEATH		ADDRESS	
RECORDS: BCH 4940 EASTERN AVENUE #21224		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) Cerebral vascular accident 4 days		(B) Hypertensive cardiovascular disease ?			
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-25 19 66 to June 29 19 66, that (I) (we) last saw the deceased alive on June 29 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Ross T. Krueger		June 29, 1966		Ross T. Krueger	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7/2/66		Holly Hill Memorial Gardens	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 5 1966		Robert E. Farkner		James E. Brudzinski	
24D. LOCATION (City, town, or county) (State)		24E. ADDRESS		24F. ADDRESS	
Baltimore County, Md.		1407 Eastern Ave. #21			

North Carolina
Amelia Hinton

John Hinton
Horton

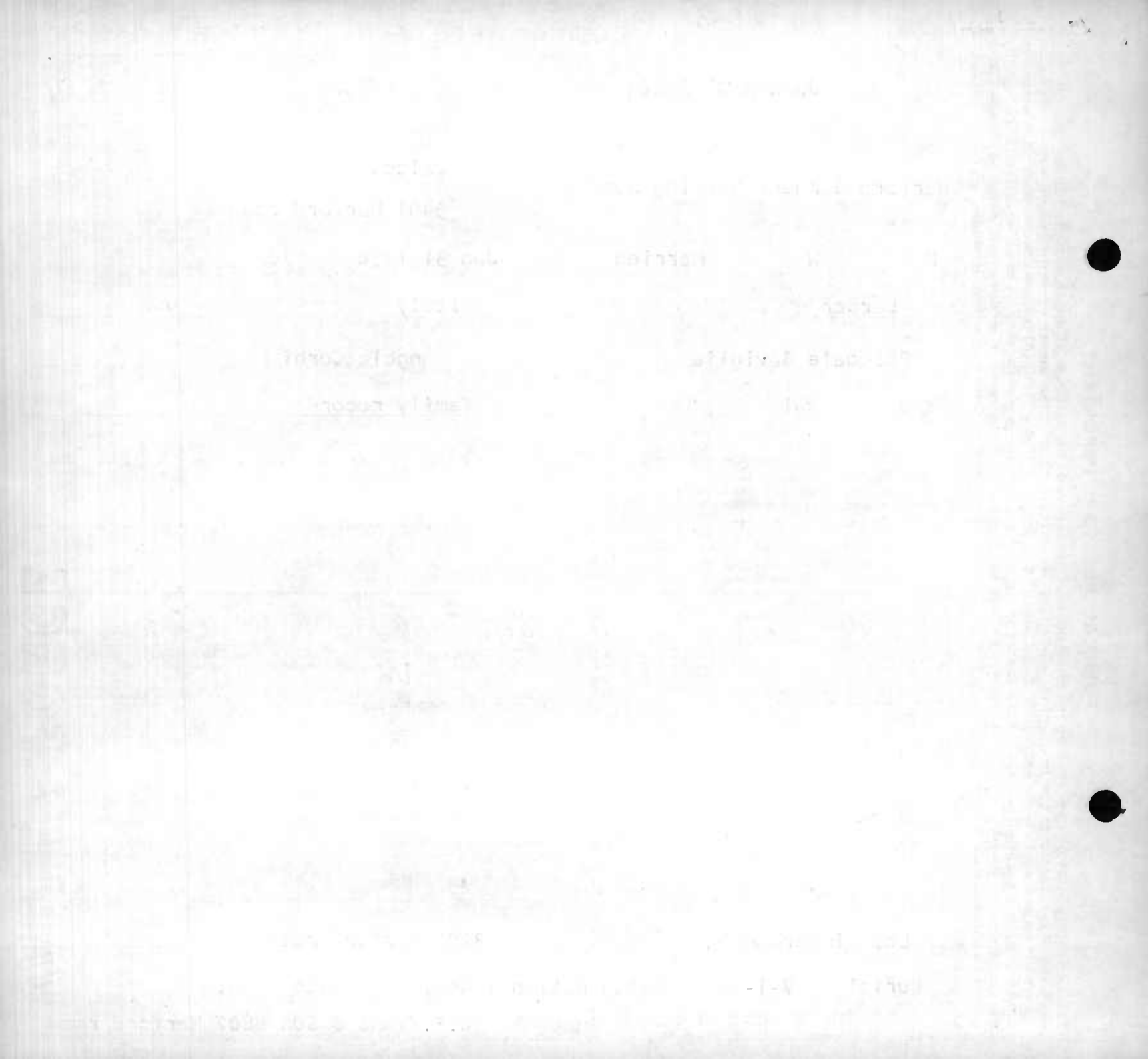
215 10 1000

10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06683				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06683	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No. 66 06683	
1. NAME OF DECEASED (Type or Print) JOSEPH GAVIGLIA				2. DATE AND HOUR OF DEATH 6/29/66 3:00 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto			
FULL NAME OF HOSPITAL OR INSTITUTION Harford Gardens Nursing Home 90				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.			
				D. STREET ADDRESS (If rural, give location) 9401 Harford road			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan 31 1896	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber			11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Pasquale Gaviglia			14. MOTHER'S MAIDEN NAME Angela Corbi				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Family records		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 450.04260X (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Generalized Arteriosclerosis			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Several Years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus						Several years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 23 1966 to June 27 1966 , that (I) we last saw the deceased alive on June 27 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Loy Zimmerman M.D.				23B. DATE SIGNED July 1, 66			
23C. PHYSICIAN'S NAME (Type) Loy Zimmerman				23D. ADDRESS 3202 Harford road			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8-1-66		24C. NAME of CEMETERY or CREMATORY Balto National Cem.		24D. LOCATION (City, town, or county) (State) Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR R. E. Johnson		25C. FUNERAL DIRECTOR C.F. EVANS & SON		ADDRESS 8802 Harford road	



1
0-351

66 06684

BALTIMORE CITY HEALTH DEPARTMENT

66 06684

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH C. O'DONOVAN

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1966 7:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2015 St. Paul Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2015 St. Paul Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

JAN. 29, 1906

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MANAGER-OWNER-J.C.O'DONOVAN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

DANIEL O'DONOVAN

14. MOTHER'S MAIDEN NAME

LILLY WHITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. J.C.O'Donovan 2015 St. Paul St.

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Fatty Cirrhosis.
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Heart Disease.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
6/30/6623A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7/2/66

23C. NAME of CEMETERY or CREMATORY

WOODLAWN CEMETERY

23D. LOCATION (City, town, or county) (State)

BALTIMORE, MD.

24A. DATE RECEIVED BY HEALTH DEPT.

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

H. W. MEARS & SON 805 N. CALVERT ST.

ADDRESS

1
P-635

66 06685

BALTIMORE CITY HEALTH DEPARTMENT

66 06685

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EUGENE

PERKINS, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1966

11:20 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

5222 Florence Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5222 Florence Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

Aug. 5, 1896

9. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

retired clerk

10B. KIND OF BUSINESS OR INDUSTRY

postal dept USA

11. BIRTHPLACE (State or foreign country)

Balto

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Eugene Perkins

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

WW1

16. SOCIAL
SECURITY NO.

216 44 3308

17. INFORMANT

Eugene Perkins, 115 Applan Way, Pasadena, Md.

ADDRESS

1B.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and Arteriosclerotic
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/30/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

July 2, 1966

23C. NAME of CEMETERY or CREMATORY

Lorraine Pk. Cem.

23D. LOCATION

(City, town, or county)

(State)

Windsor Mill Rd. Balto Co. Md

Md. 21133

24A. DATE REC'D BY HEALTH DEPT

JUL 5 1966

24B. NAME OF REGISTRAR

P. L. Byers

24C. FUNERAL DIRECTOR

Loring Byers, 8728 Liberty Rd., Randallstown

WALL

12. 2. 1966

withheld

USA

12. 2. 1966

postal dep. USA

retired clerk

unknown

unknown

12. 2. 1966, Bureau of the FBI, New York, NY, Bureau of the FBI, New York, NY

12. 2. 1966

WALL

12. 2. 1966, Bureau of the FBI, New York, NY, Bureau of the FBI, New York, NY

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12. 2. 1966

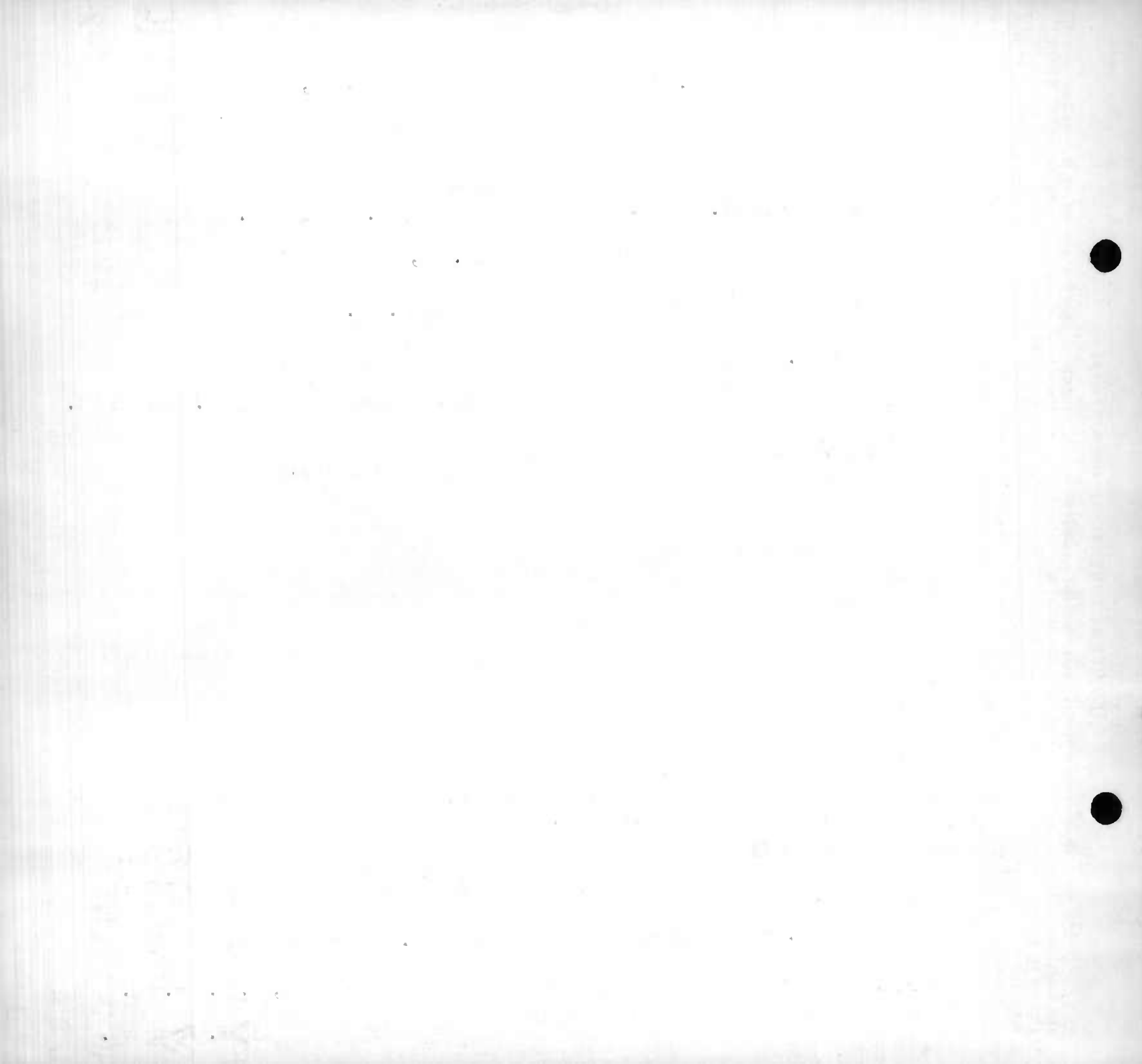
12. 2. 1966

12. 2. 1966, Bureau of the FBI, New York, NY, Bureau of the FBI, New York, NY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. _____	
BIRTH NO. 06 06686		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH June 29, 1966	
M.E. CASE NO. _____		1. NAME OF DECEASED Margaret I. Farren		2. DATE AND HOUR OF DEATH June 29, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1450 Boyle St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2302		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH Jan. 31, 1915		9. AGE (In years last birthday) 51		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME John H. Keith	
14. MOTHER'S MAIDEN NAME Louise Ousterhous		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Ellwood Farren		ADDRESS 15 E. Randall St.		18. CAUSE OF DEATH Cirrhosis of the liver	
INTERVAL BETWEEN ONSET AND DEATH ?		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 4, 1966 to June 29, 1966 that (I) (we) last saw the deceased alive on June 27, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry Deibel				23B. DATE SIGNED 7/1/66	
23C. PHYSICIAN'S NAME (Type) Dr. Harry Deibel				23D. ADDRESS 1226 S. Hanover Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE JUL 5 1966		24C. NAME OF CEMETERY or CREMATORY Holy Cross	
24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. 6/29/66		25B. NAME OF REGISTRAR Mc Cully	
25C. FUNERAL DIRECTOR Mc Cully		ADDRESS 130 E. Fort Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 06687		BALTIMORE CITY HEALTH DEPARTMENT		66 06687	
BIRTH NO. (SHORTESS)		CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Shortess Eleanor (MARY ELLEN)</i>		2. DATE AND HOUR OF DEATH <i>6-29-66 12:15 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		LEGAL: CONNECTICUT <i>1-06</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		A. STATE <i>Maryland</i>		C. CITY OR TOWN (If outside city limits, write FULL and give township) <i>Baltimore</i>	
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>525 North Wolfe Street</i>		VVA DSTOCK	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>2-10-94</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Reg nurse</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Private Duty</i>		11. BIRTHPLACE (State or foreign country) <i>Probably: Penna. Jamison City, Columbia Co.,</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Thomas Shortess</i>		14. MOTHER'S MAIDEN NAME <i>Mary Seidel</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Doubtful</i>		16. SOCIAL SECURITY NO. <i>216-32-5502</i>		17. INFORMANT: <i>Nephew</i> ADDRESS <i>Madison, Tenn. 37115</i>	
18. <i>175.01</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)		(A) <i>RESPIRATORY ARREST</i>			
ANTECEDENT CAUSES		(B) <i>METASTATIC ADENOCARCINOMA</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>OF THE OVARY</i>		<i>4 MOS</i>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>6-16</i> 19 <i>66</i> to <i>6-29</i> 19 <i>66</i> , that (2) (we) last saw the deceased alive on <i>6-29</i> 19 <i>66</i> and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joel F. Habener</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6-29-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Joel F. Habener</i>		23D. ADDRESS <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>7/1/1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>GREEN MOUNT CEMETERY</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Stewart & Mowen Co., 108 W. North Av.</i>		ADDRESS <i>Balto., 1</i>	

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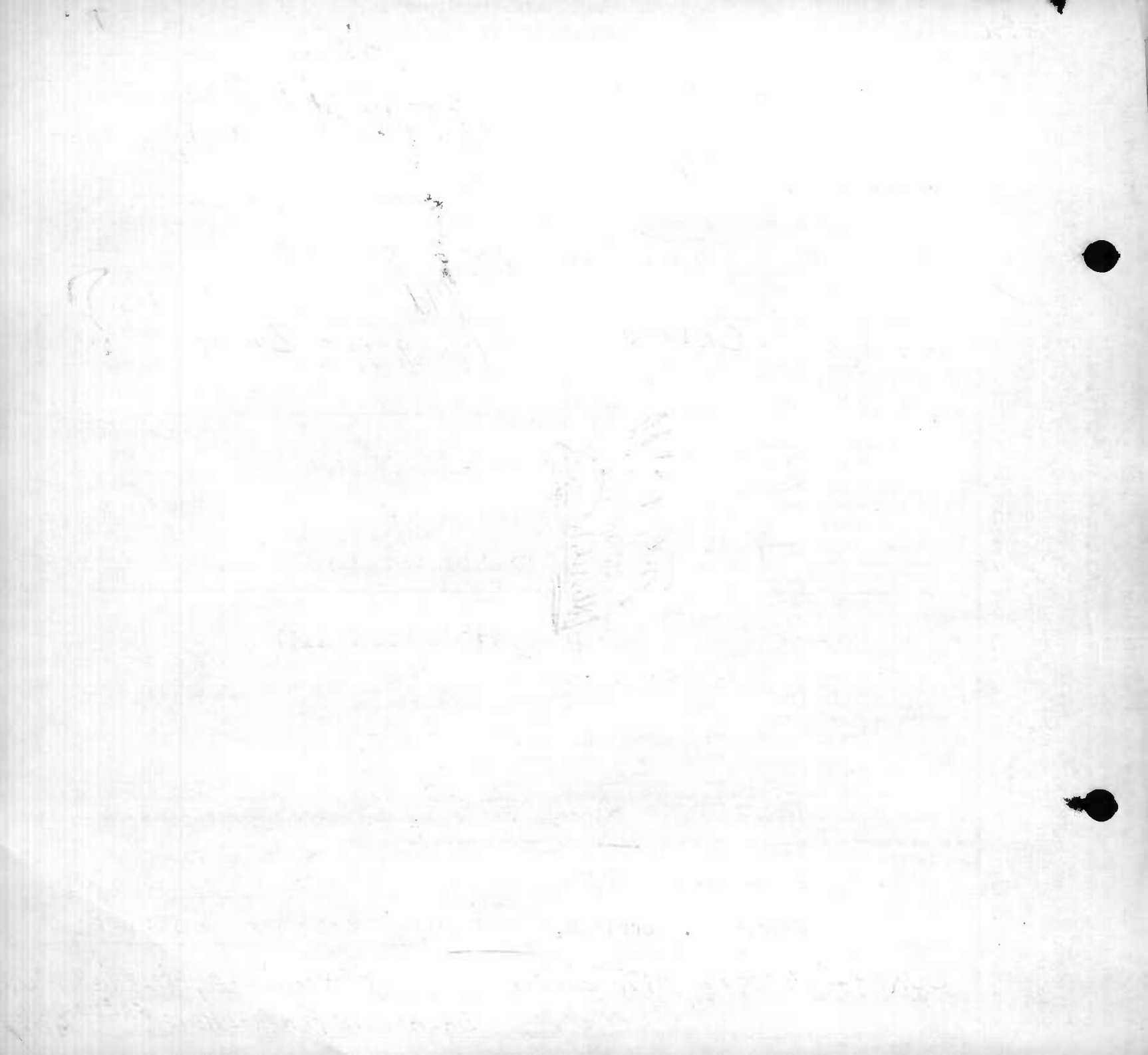
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Release Approved by Medical Examiner 1:30AM 6-30-66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06688	
BIRTH NO. 66 06688		CERTIFICATE OF DEATH		Registered No. 66 06688	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CRAMER JOHN LAWRENCE		2. DATE AND HOUR OF DEATH 6-30-66 12:20 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Springfield State Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Carroll Co - 56-00	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		D. STREET ADDRESS (If rural, give location)			
5. SEX M	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify) MARY CRAMER (wife)	8. DATE OF BIRTH 3-28-08	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George W. CRAMER		14. MOTHER'S MAIDEN NAME MARGARET ZIMMERMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS ABSTRACT SPRINGFIELD STATE HOSP	
18. 502.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH PULMONARY ABCESS		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS.	
ANTECEDENT CAUSES		PNEUMONIA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CHRONIC BRONCHITIS & EMPHYSEMA - YEARS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		TRACHEOSTOMY			
19A. DATE OF OPERATION 6-30-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AIRWAY OBSTRUCTION		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-29-66 19 to 6-30-66 19, that (I) (we) lost saw the deceased alive on June 30, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles S. Harrison, M.D. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6-30-66	
23C. PHYSICIAN'S NAME (Type) Charles S. Harrison, M.D.				23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-3-66		24C. NAME OF CEMETERY MT. ZION	
24D. LOCATION (City, town, or county) (State) FEAGAVILLE, FREDERICK MD.		25A. DATE RECORDED BY HEALTH DEPT 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR ADDRESS SALAMONE FUNERAL HOME FREDERICK MD.					



1
W-656

66 06689

BALTIMORE CITY HEALTH DEPARTMENT

66 06689

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)~~KATHRYN E. WARNER~~
~~KATHERINE~~ E. WARNER

2. DATE AND HOUR PRONOUNCED DEAD

July 4, 1966 6:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

444 N. Linwood Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

444 N. Linwood Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Nov. 16, 1880

9. AGE (In years
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Evans

14. MOTHER'S MAIDEN NAME

Marinda ? ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

unknown

17. INFORMANT

ADDRESS

Jess Warner 444 N. Linwood Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Russell S. Fisher
M.D.
Russell S. Fisher, M.D.CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 4, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/7/66

23C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

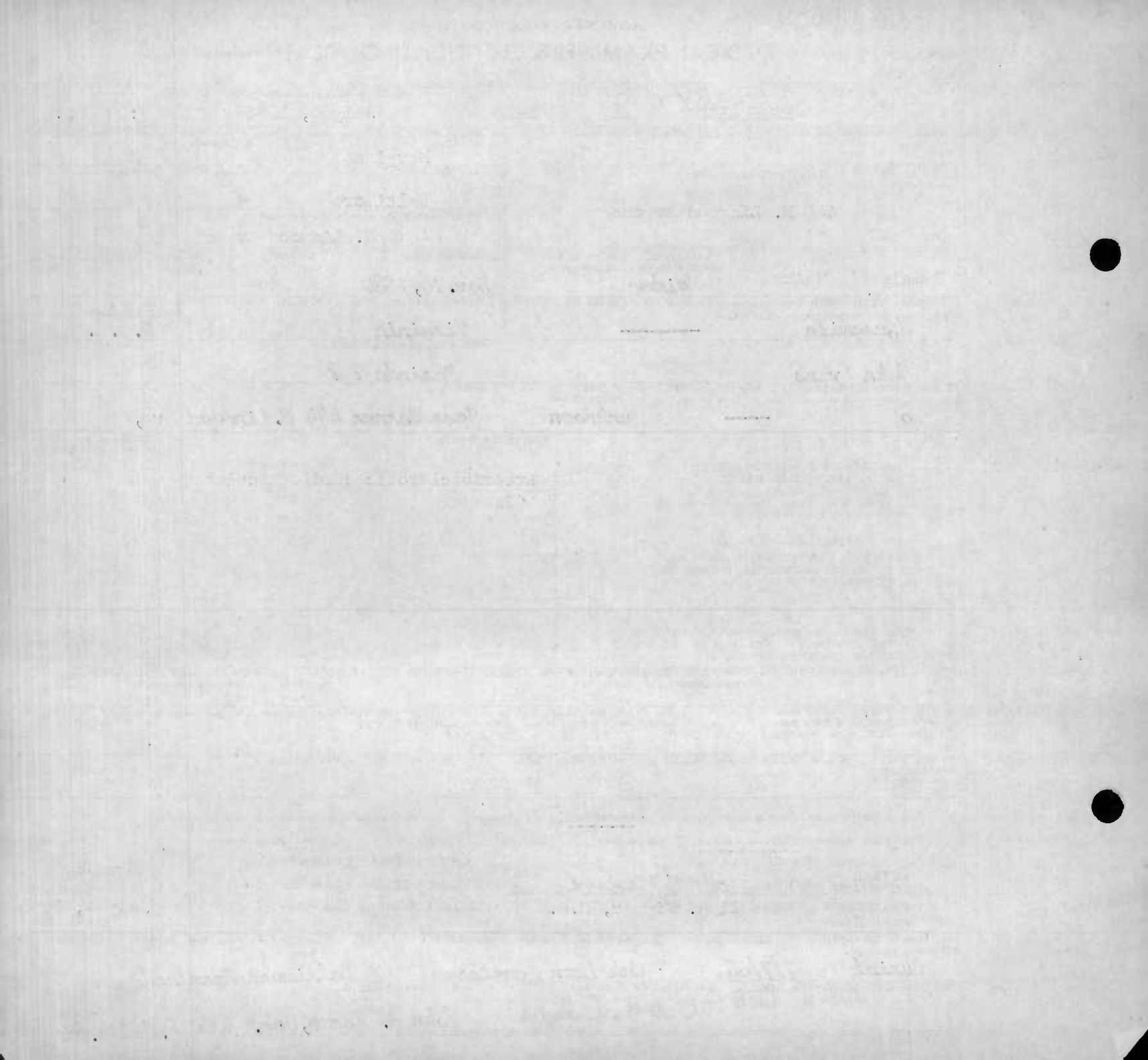
JUL 8 1966

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto. St



F-600

66 06690

BALTIMORE CITY HEALTH DEPARTMENT

66 06690

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) THOMAS FOY		2. DATE AND HOUR PRONOUNCED DEAD 3 July 1966 8:55 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 213 N. Lakewood Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 213 N. Lakewood Ave.	
5. SEX male	6. RACE caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH April 5, 1885
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock clerk		10B. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) 85
13. FATHER'S NAME Patrick Foy		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) no		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 216-14-4158		14. MOTHER'S MAIDEN NAME Mary Whalen	
17. INFORMANT John P. McDonough		ADDRESS 4223 Ivanhoe Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO	
19A. DATE OF OPERATION 0		20A. AUTOPSY? (Yes or No) no	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Petty		DATE SIGNED 7/3/66	
EXAMINER'S NAME (Type) Charles S. Petty		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE 7/6/66	23C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	23D. LOCATION (City, town, or county) (State) Baltimore Maryland
24A. DATE RECEIVED BY HEALTH DEPT. JUL 5 1966		24C. FUNERAL DIRECTOR ADDRESS John A. Moran, Inc. 3000 E. Balto. St.	

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66 06691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 06691

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED.

(Type or Print)

MICHAELS, John D.

2. DATE AND HOUR OF DEATH

7-3-66 2:40 A.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

29 N. POTOMAC ST.

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9-30-90

9. AGE (in years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

coil winder

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Michaels

14. MOTHER'S MAIDEN NAME

Ella Marshall

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

213-07-1665

17. INFORMANT

RECORDS-BCH-4940 Eastern Avenue

ADDRESS

#21224

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) ruptured abdominal aneurysm acute
DUE TO(B) inferior myocardial infarction acute
DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-2 19 66 to 7-3 19 66,
that (I) (we) last saw the deceased alive on 7-3 19 66 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David Summer

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7-3-66

23C. PHYSICIAN'S
NAME (Type)

David Summer

M.D.

23D. ADDRESS

BCH-4940 Eastern Avenue-Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/6/66

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 5 1966

25B. NAME OF REGISTRAR

P. A. E. F. Adams

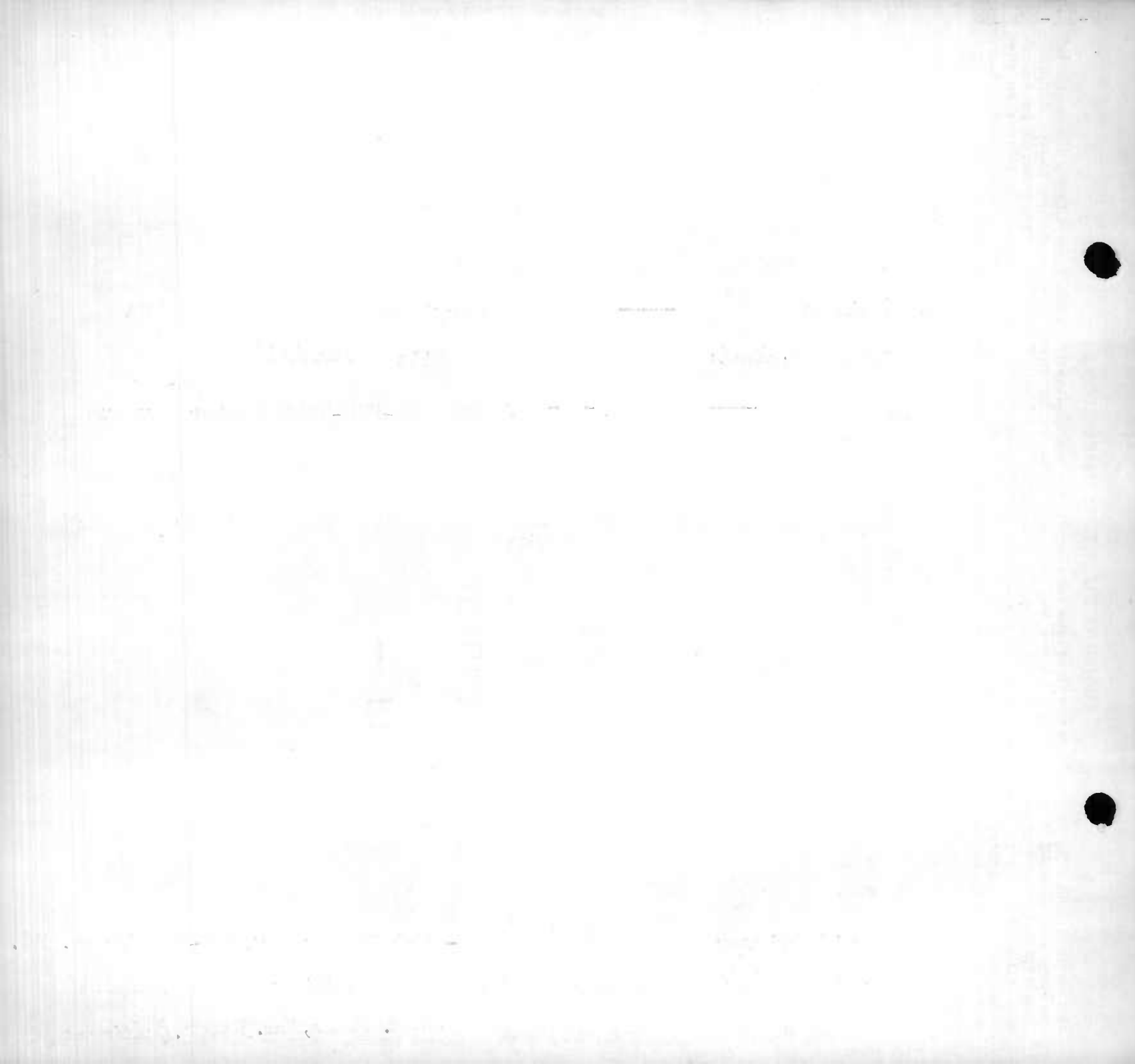
25C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Baltimore St

ADDRESS

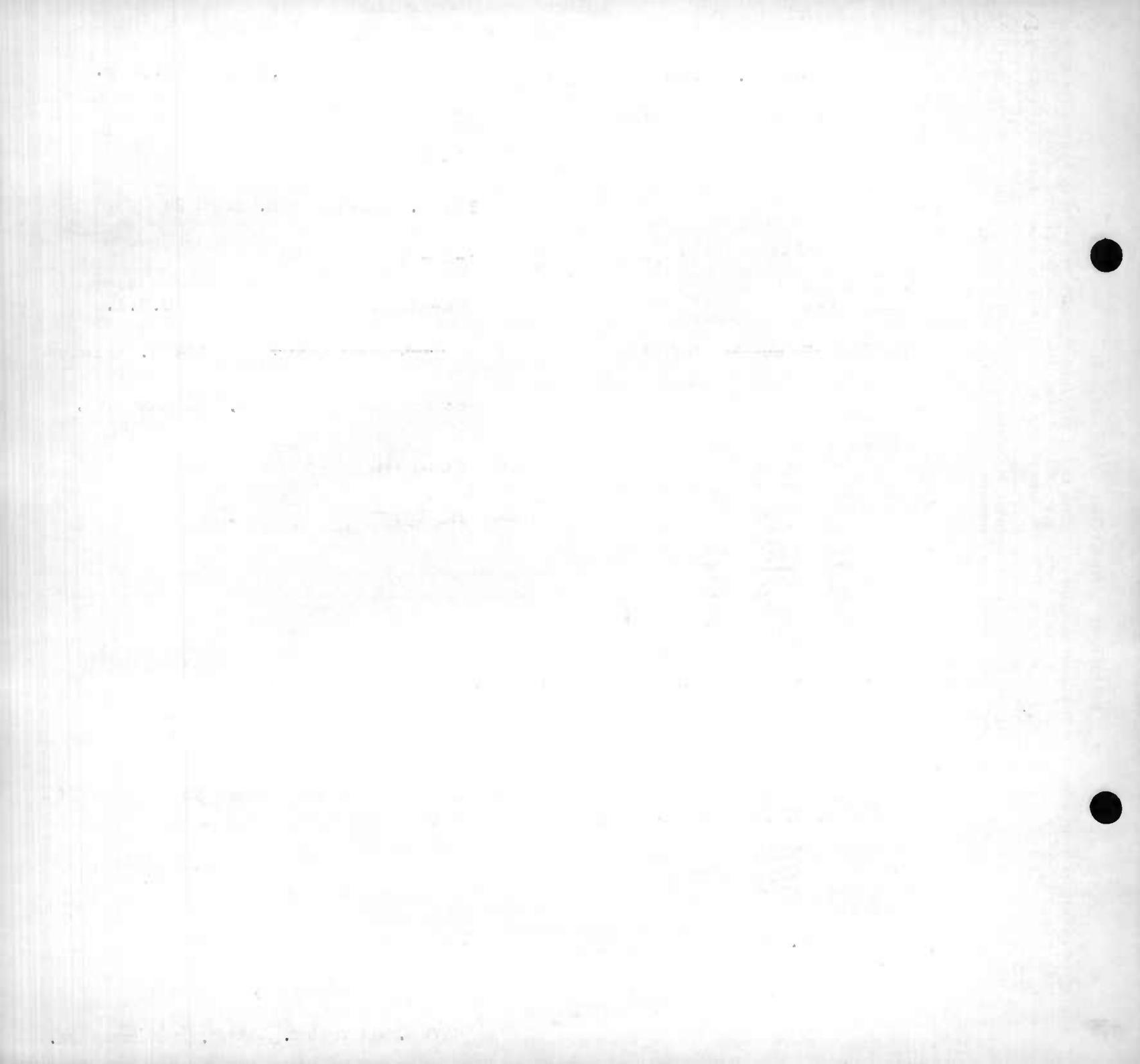
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06692	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Iona A. Sauer		2. DATE AND HOUR OF DEATH June 30, 1966 12:50 p.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 35		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 124 S. ELLWOOD AVE. ZONE 24			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 3-10-21	9. AGE (In years last birthday) 45	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HERBERT BOCKMAN Bachman		14. MOTHER'S MAIDEN NAME FREDDA THALMAIN Frieda Thalheim		124 S. Ellwood	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Herbert Bachman 124 S. Ellwood Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 153.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Carcinoma of transverse colon (B) DUE TO With Metastasis to liver (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION June 13, 1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Colon		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 12 1966 to June 30 1966, that (I) (we) last saw the deceased alive on June 30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel J. Tan		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/30/66	
23C. PHYSICIAN'S NAME (Type) MANUEL J. TAN		23D. ADDRESS M.D. CHURCH HOME AND HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE JUL 5 7 1966	24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25C. FUNERAL DIRECTOR ADDRESS John A. Moran Inc. 3000 E. Baltimore St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06693				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06693	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WILLIAM ROUNDTREE				2. DATE AND HOUR OF DEATH June 22, 1966 1 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 603	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 2122 E. BALTIMORE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 10/11/76	9. AGE (In years lost birthday) 89	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 215-03-2896		17. INFORMANT PATIENT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PERITONITIS, Septicemia, wound infection, Pneumonia (?)				INTERVAL BETWEEN ONSET AND DEATH 9 days + 4 days			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 11 1966 to June 22 1966 , that (I) (we) last saw the deceased alive on June 22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Manuel J. Tan				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 22, 1966	
23C. PHYSICIAN'S NAME (Type) MANUEL J. TAN.				23D. ADDRESS Church Home and Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE JUL 5 1966		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR John A. Moran, Inc.		25C. FUNERAL DIRECTOR John A. Moran, Inc.		ADDRESS 3000 E. Baltimore St.	

X

T-5112

66 06694

BALTIMORE CITY HEALTH DEPARTMENT

66 06694

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) EDGAR THOMPSON		2. DATE AND HOUR PRONOUNCED DEAD 2 July 1966 4:15 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-04 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1915 E. Chase St.	
5. SEX male	6. RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 9 - 24
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY Student	9. AGE (In years last birthday) 42
13. FATHER'S NAME Walter Thompson		14. MOTHER'S MAIDEN NAME Emma Carter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) 2		16. SOCIAL SECURITY NO. 239-14-2828	17. INFORMANT Family
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 981 X I		CAUSE OF DEATH (A) Gunshot wound of abdomen DUE TO (B) DUE TO (C) DUE TO	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
21C. WHERE DID INJURY OCCUR? 1915 E. Chase St.			
21D. TIME OF INJURY (APPROX.) July 2, 1966 3:25 a.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? shot during altercation	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE July 7/66	23C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery
23D. LOCATION (City, town, or county) (State) Baltimore, Md.			
24A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		24B. NAME OF REGISTRAR Robert E. Taylor	24C. FUNERAL DIRECTOR Robert Williams
		ADDRESS 1701 N Bond	

THE UNIVERSITY OF CHICAGO PRESS

CHICAGO, ILLINOIS

1954

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CHICAGO, ILLINOIS

1954

the body of Sadie Handy was released as non-med
by Dr. Hirsch to The Johns Hopkins Hospital 7-1-66
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No.	
BIRTH NO.		68 06695		68 06695	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		SADIE HANDY		2. DATE AND HOUR OF DEATH 6-30-66 11.20 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND		704	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
THE JOHNS HOPKINS HOSPITAL		D. STREET ADDRESS (If rural, give location)		935 N. DALLAS STREET	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-09-95	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Charles Carr		14. MOTHER'S MAIDEN NAME Catherine Stanley		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Family	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 181.0 I CAUSE OF DEATH Ca bladder		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/30/66 to 6/30/66 that (I) (we) last saw the deceased alive on 6/30/66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE James Louis		23B. DATE SIGNED 6/30/66	
23C. PHYSICIAN'S NAME (Type) JAMES LOUIS		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial July 5/66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A Co Md	
25A. DECEASED BY 1966 DEATH		25B. NAME OF REGISTRAR Robert E. Williams		25C. FUNERAL DIRECTOR Robert E. Williams 1701 N Bond St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 06696					CERTIFICATE OF DEATH					Registered No. 66 06696									
1. NAME OF DECEASED (Type or Print) Irene A. Timpson					2. DATE AND HOUR OF DEATH 8 July 2 1966 8:40 P.M.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)														
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital					A. STATE Maryland					B. COUNTY 15-04									
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore														
D. STREET ADDRESS (If rural, give location) 2024 N. Pulaski St.																			
5. SEX F		6. RACE N		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 4/11/12		9. AGE (In years last birthday) 54		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY —					11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Franklin Johnson					14. MOTHER'S MAIDEN NAME Cecelia ———														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. —					17. INFORMANT Patient					ADDRESS				
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Uremia					CAUSE OF DEATH (A) DUE TO Uremia					INTERVAL BETWEEN ONSET AND DEATH 8 yrs									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Glomerulosclerosis					(B) DUE TO Glomerulosclerosis					10 yrs									
					(C) DUE TO Diabetes Mellitus					15 yrs									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from April 13 1966 to July 2 1966 , that (I) (we) last saw the deceased alive on July 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE W. Michael Gould					M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 7/2/66									
23C. PHYSICIAN'S NAME (Type)					M.D.					23D. ADDRESS									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 7-6-66					24C. NAME of CEMETERY or CREMATORY Baltimore Nat'l Cemetery					24D. LOCATION (City, town, or county) (State) Baltimore Md.				
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966					25B. NAME OF REGISTRAR Robert E. Jackson					25C. FUNERAL DIRECTOR Morton E. Dyett					ADDRESS F.H. 1701 Laurens St				

W. M. L. R. M.

X

April 12

July 12

No.

Diabetes Mellitus

Glandular Disease

Nervous

Patient

Cecilia

England

4/11/12

2024 A. P. M. 12

Franklin Johnson

Harrogate

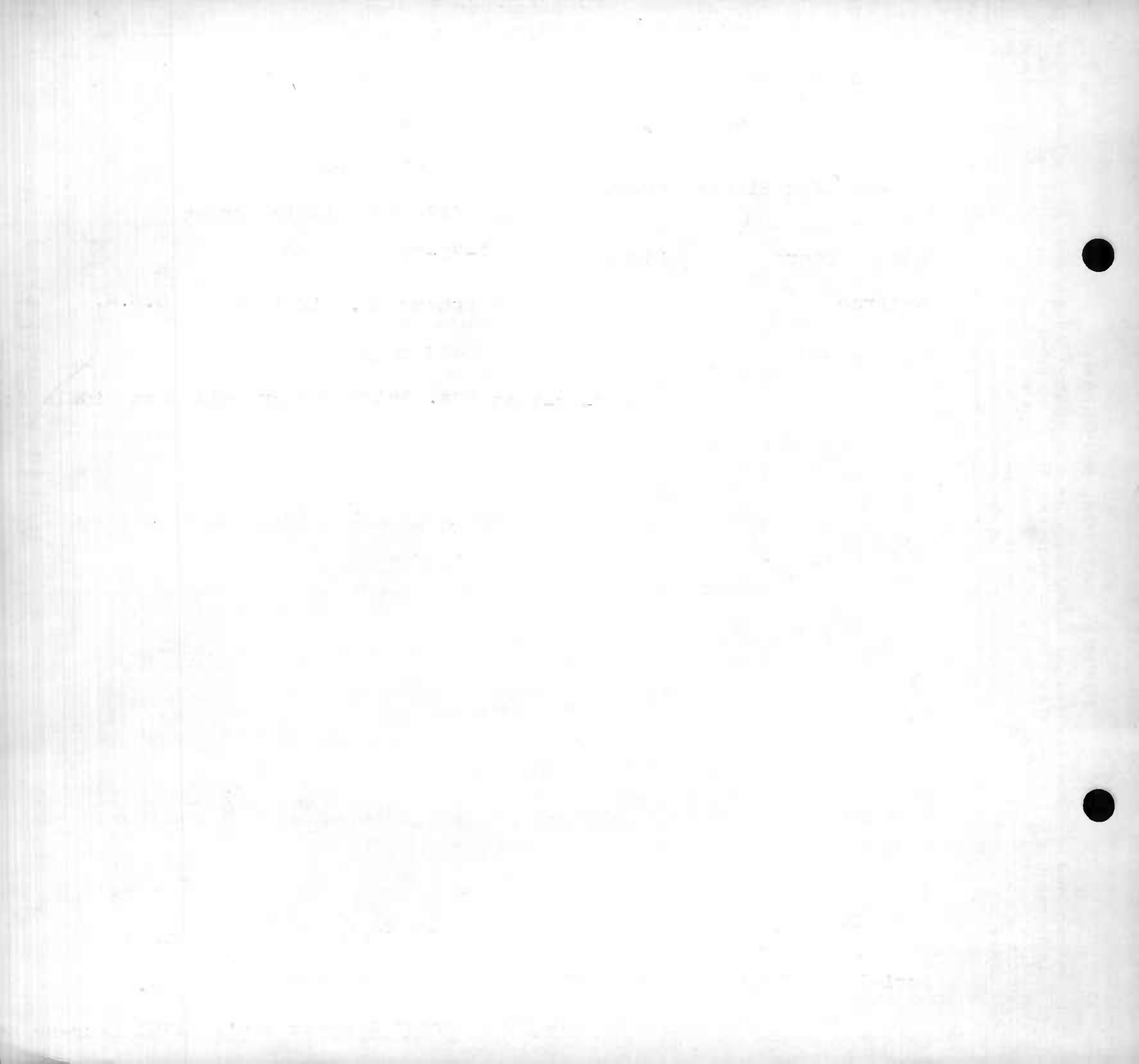
Admitted

Admitted and Discharged

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06697	
BIRTH NO. 66 06697		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) James Boyd		2. DATE AND HOUR OF DEATH July 3, 1966 17:30 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 412 East Biddle Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 412 East Biddle Street	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2-22-86	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brunsy Co. Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ANDREW BOYD		14. MOTHER'S MAIDEN NAME MARY BOYD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 226-14-7993		17. INFORMANT Mrs. Selma Waller ADDRESS 412 East Biddle St	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) Hypertensive Cardiovascular Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 7-2-66 3 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-2-1966 to 7-3-1966 , that (I) (we) last saw the deceased alive on 7-2-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. Bradshaw Higgins M.D.		23B. DATE SIGNED 7-4-66		23C. PHYSICIAN'S NAME (Type) I. Bradshaw Higgins M.D.	
23D. ADDRESS 2243 Madison Ave Baltimore Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/66	
24C. NAME OF CEMETERY or CREMATORY Good Hope		24D. LOCATION (City, town, or county) (State) Blackridge Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966	
25B. NAME OF REGISTRAR Robert E. Gellera		25C. FUNERAL DIRECTOR Morton & Dyett Fun'l		ADDRESS 1701 Laurens St	



1
D-500

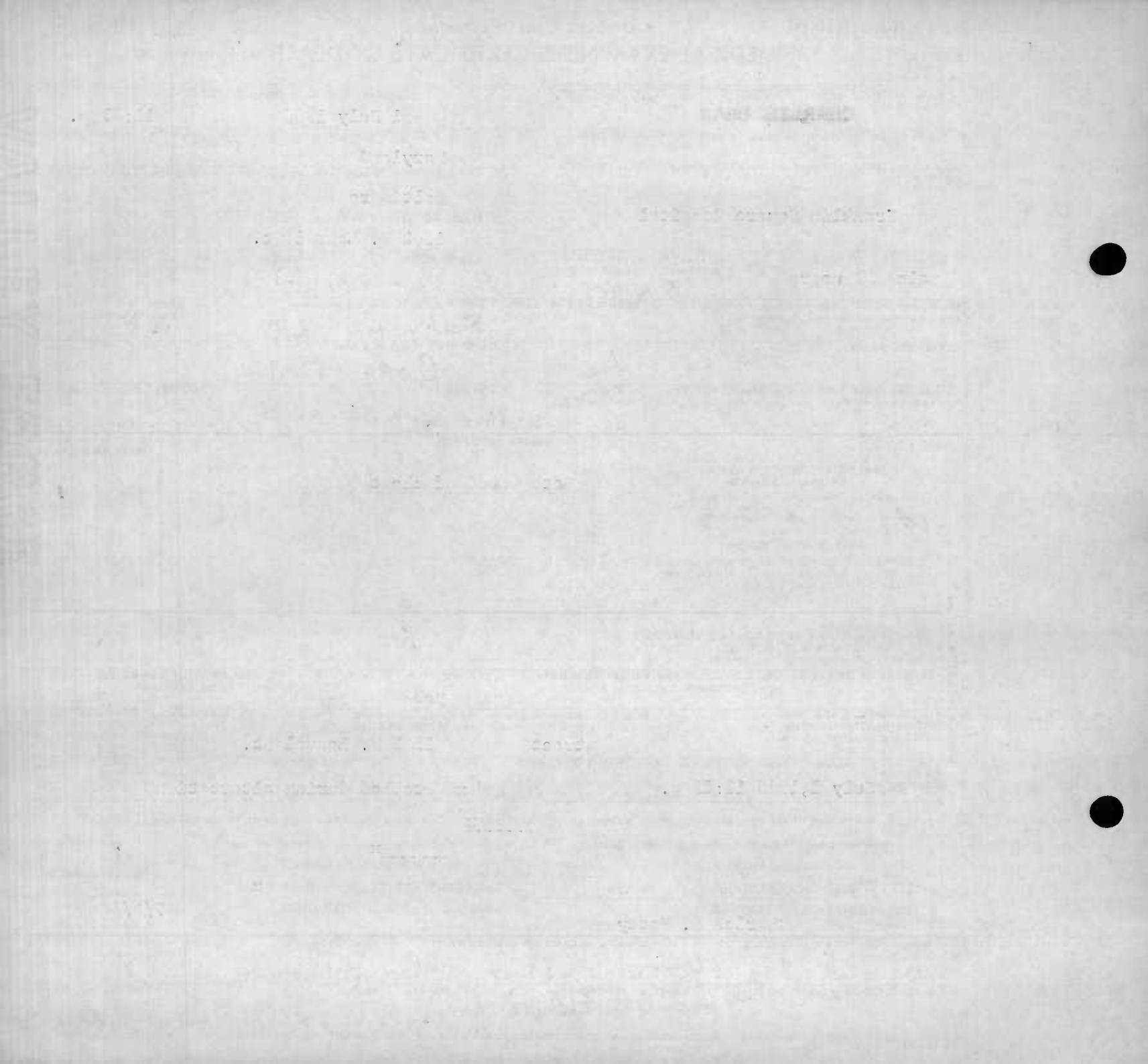
66 06698

BALTIMORE CITY HEALTH DEPARTMENT

66 06698

BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) CHARLIE DEAN			2. DATE AND HOUR PRONOUNCED DEAD 1 July 1966 11:47 p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Franklin Square Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1502 W. Lanval St.		
5. SEX male	6. RACE negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 9-24-1931	9. AGE (In years last birthday) 34	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rocky MT., N.C.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME GORA Ford		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service) Y.S. 52-54		16. SOCIAL SECURITY NO. 228-34-2175		17. INFORMANT Mrs. NAN EVANS 1808 W. FRANKLIN ST	
18. CAUSE OF DEATH 1-982X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Satb wound of chest ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1502 W. Lanval St.	
21D. TIME OF INJURY (APPROX.) July 1, 1966 11:15 p.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? stabbed during altercation	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/2/66					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7-6-66		23C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
24A. DATE REC'D BY HEALTH DEPT. 7-6-66		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR Morton & Dyer H.F.H.	
				24D. ADDRESS 1701 Laurens St.	

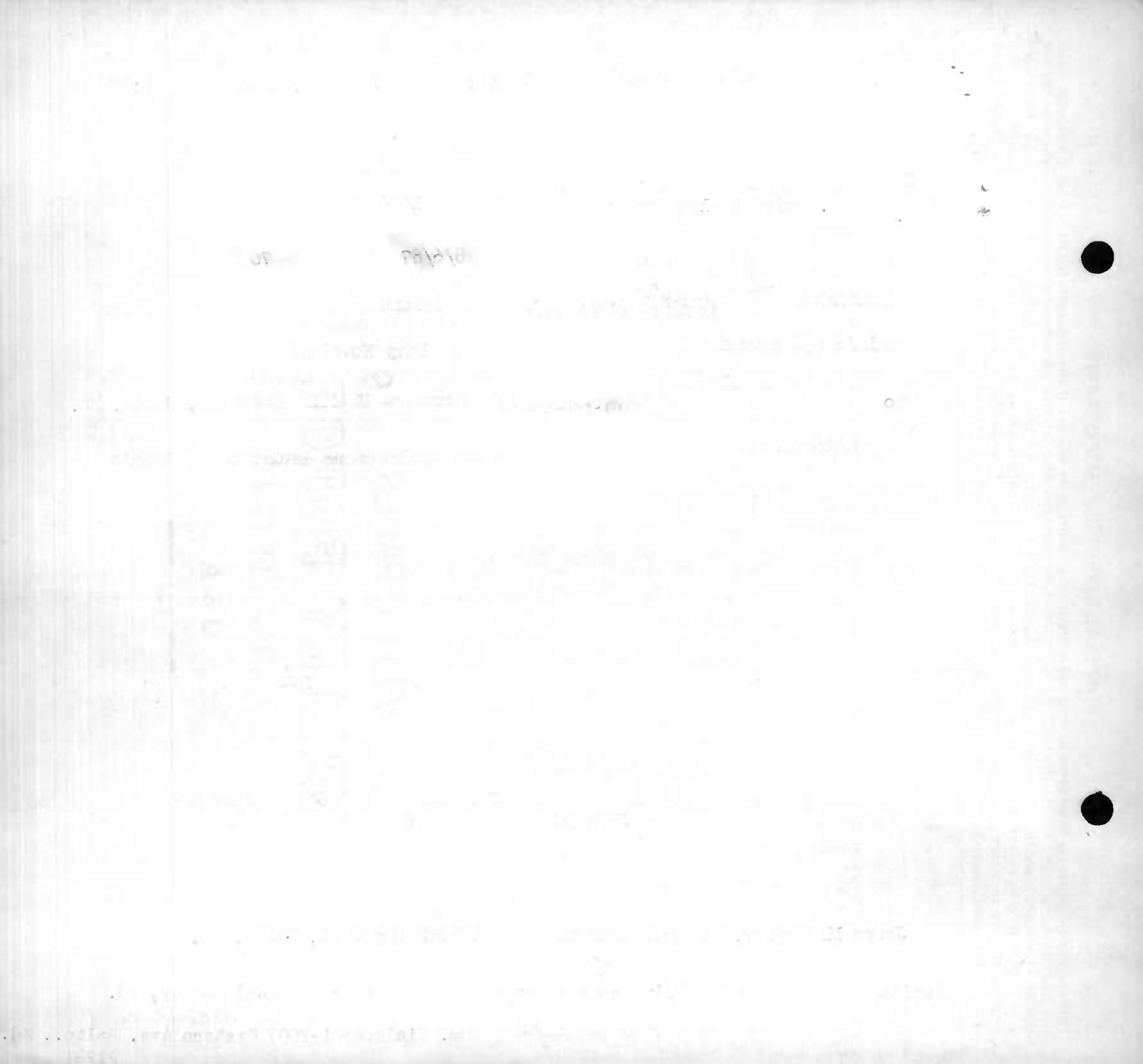
17875.2



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06699	
BIRTH NO. 66 06699		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SOPHIE ANDERCYK (ANDREJCZYK)		2. DATE AND HOUR OF DEATH June 30, 1966 2:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 25-05			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1636 Hazel Street			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 8/6/87	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? Poland		13. FATHER'S NAME Dominic Ojdinowski			
14. MOTHER'S MAIDEN NAME Mary Kovalcyk		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 217-09-6458		17. INFORMANT (M. SCHNEIDER) ADDRESS Records- US PHS Hospital, Balto, Md.			
18. 204.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myelogenous leukemia		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from June 14 1966 to June 30 1966 , that (1) (we) last saw the deceased alive on June 30 1966 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James M. Weaver		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/1/66	
23C. PHYSICIAN'S NAME (Type) James M. Weaver, Medical Director		23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-5-66		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel County, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966			
25B. NAME OF REGISTRAR Wm. Fialkowski		25C. FUNERAL DIRECTOR Wm. Fialkowski-2007 Eastern Ave. Balto., Md.			



1
M-500

66 06700

BALTIMORE CITY HEALTH DEPARTMENT

66 06700

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

EUGENE T. MEEHAN

2. DATE AND HOUR PRONOUNCED DEAD

3 July 1966

12:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1219 Glyndon Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1219 Glyndon Ave. 21223

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

7/23/1928

9. AGE (In years
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Eugene P. Meehan

14. MOTHER'S MAIDEN NAME

Almeda Kell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Almeda Meehan - 1219 Glyndon Ave. (21223)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebral palsy
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S/ Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/3/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/6/66

23C. NAME of CEMETERY or CREMATORY

Lorraine Park

23D. LOCATION

Woodlawn, Baltimore

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 5 1966

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

John J. Cowan & Son, Inc. 901 Hollins St.

ADDRESS

Baltimore, Md.

WALLIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06701	
BIRTH NO. 66 06701		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Sheetz, John, Edgar</i>		2. DATE AND HOUR OF DEATH <i>2 July 1966 4:45 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hosp.</i>		A. STATE <i>Md.</i> B. COUNTY			
5. SEX <i>Male</i>		6. RACE <i>Can.</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>	
8. DATE OF BIRTH <i>26 Aug 1913</i>		9. AGE (In years last birthday) <i>52</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Tool & die maker</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Sheetz</i>		14. MOTHER'S MAIDEN NAME <i>Oleta Barnes</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-14-6563</i>		17. INFORMANT <i>Daughter</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of rt. lung with metastasis to hilar lymph nodes liver & retroperitoneal space</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12 June 1966</i> to <i>2 July 1966</i> , that (I) (we) last saw the deceased alive on <i>2 July 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>D. Santos</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>2 July 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>D. Santos</i>		23D. ADDRESS <i>M.D.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/5/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Trinburg Church Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Trinburg, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>	
25C. FUNERAL DIRECTOR <i>J. S. Myers, Jr.</i>		25D. ADDRESS <i>Westminster, Md.</i>			

212-14-4243

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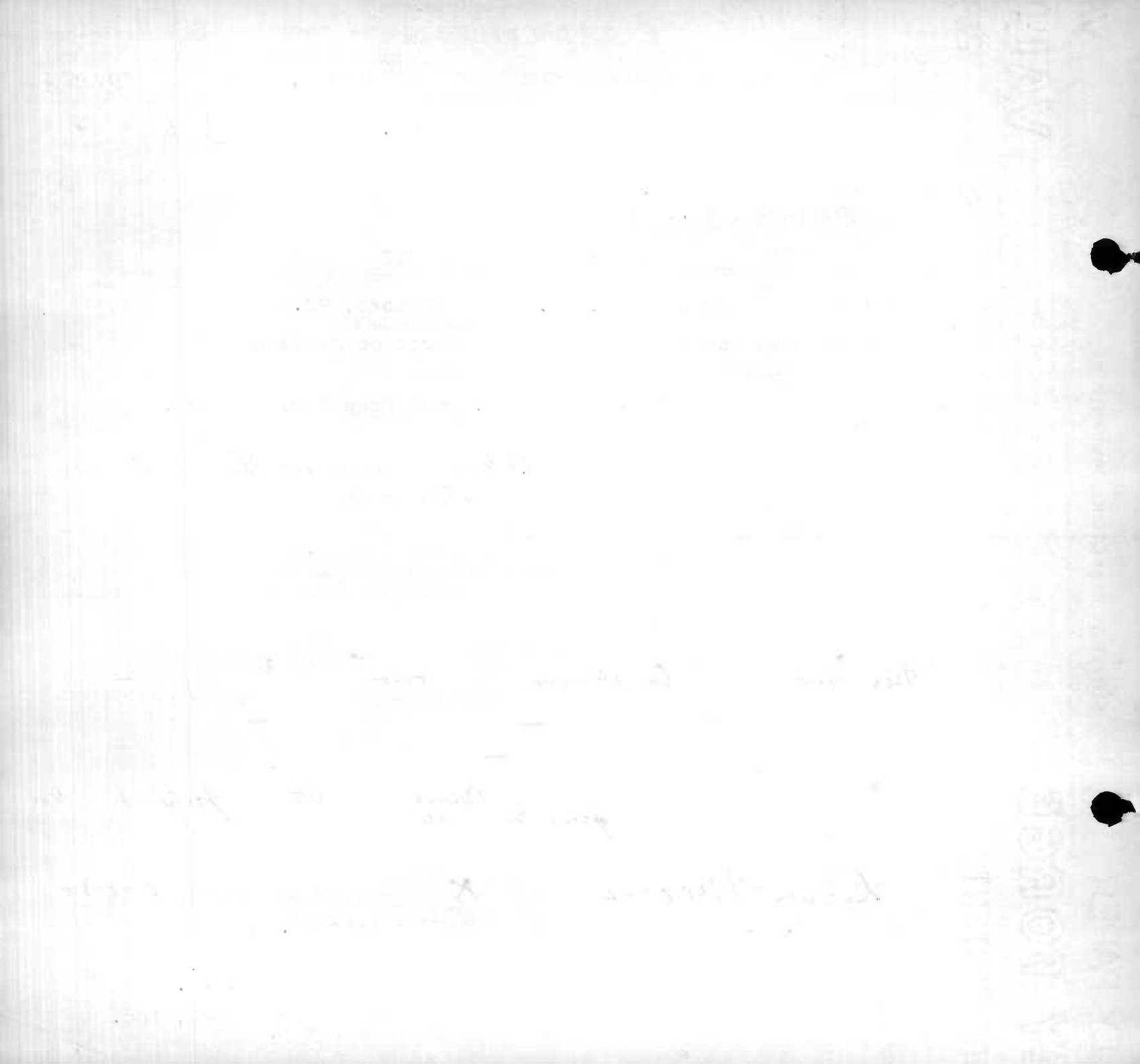
12 June

1901 2/2/12
J. S. [illegible]
[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06702	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 66 06702</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) FRANCES LORRAINE CONNOLLY</p> </div> <div> <p>2. DATE AND HOUR OF DEATH July 1, 1966 10:15 A.M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>3304 Brendan Ave. Baltimore, Md., 21213</p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE Md. B. COUNTY 21213</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p> <p>D. STREET ADDRESS (If rural, give location) 3304 Brendan Avenue</p>		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 5/18/1927	9. AGE (In years last birthday) 39	<p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10B. KIND OF BUSINESS OR INDUSTRY C & P Tel. Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Hugh Dean Nevin			14. MOTHER'S MAIDEN NAME Gertrude Jamison		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-20-2142		17. INFORMANT ADDRESS E. Paul Connolly, husband, above	
<p>18. 151X I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>(A) Adeno-carcinoma of stomach</p> <p>DUE TO</p> <p>(B) _____</p> <p>DUE TO</p> <p>(C) _____</p> <p>INTERVAL BETWEEN ONSET AND DEATH 6 mo.</p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION Nov. 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca stomach		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (this hospital) attended the deceased from April 1965 to July 1, 1966, that (I) (we) last saw the deceased alive on June 30, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE Dr. J. Duer Moores				23B. DATE SIGNED 7-1-66	
23C. PHYSICIAN'S NAME (Type) Dr. J. Duer Moores		23D. ADDRESS 3105 Belair Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/66		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06703		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06703	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BERTHA HOPKINS		2. DATE AND HOUR OF DEATH 6-28-66 620A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 15-13			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO			
		D. STREET ADDRESS (If rural, give location) 4343 Reisterstown Rd			
5. SEX F.	6. RACE C.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 1-9-90	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Wm. Maddox		14. MOTHER'S MAIDEN NAME ROSINA SMITH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth Claggett ADDRESS 4343 Reisterstown Rd	
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Mid brain Thrombosis DUE TO (B) Virus Pneumonia DUE TO (C) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 to 4 hours 2 days unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1954 to 6-25 1966 , that (I) (we) last saw the deceased alive on 6-25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John T. Chissell		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-30-66	
23C. PHYSICIAN'S NAME (Type) John T. Chissell		M.D.		23D. ADDRESS 1038 Edmundson Ave Baltimore Md 21223	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/2/66	24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) D. A. County, Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Paul E. Jenkins		25C. FUNERAL DIRECTOR Joseph G. Locko Jr ADDRESS 1304 N. Central Ave	

3

General and Assistant
Three Persons
M. J. Brown, Treasurer

6-22-22

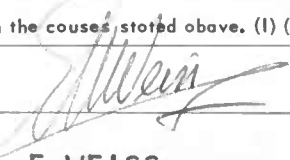
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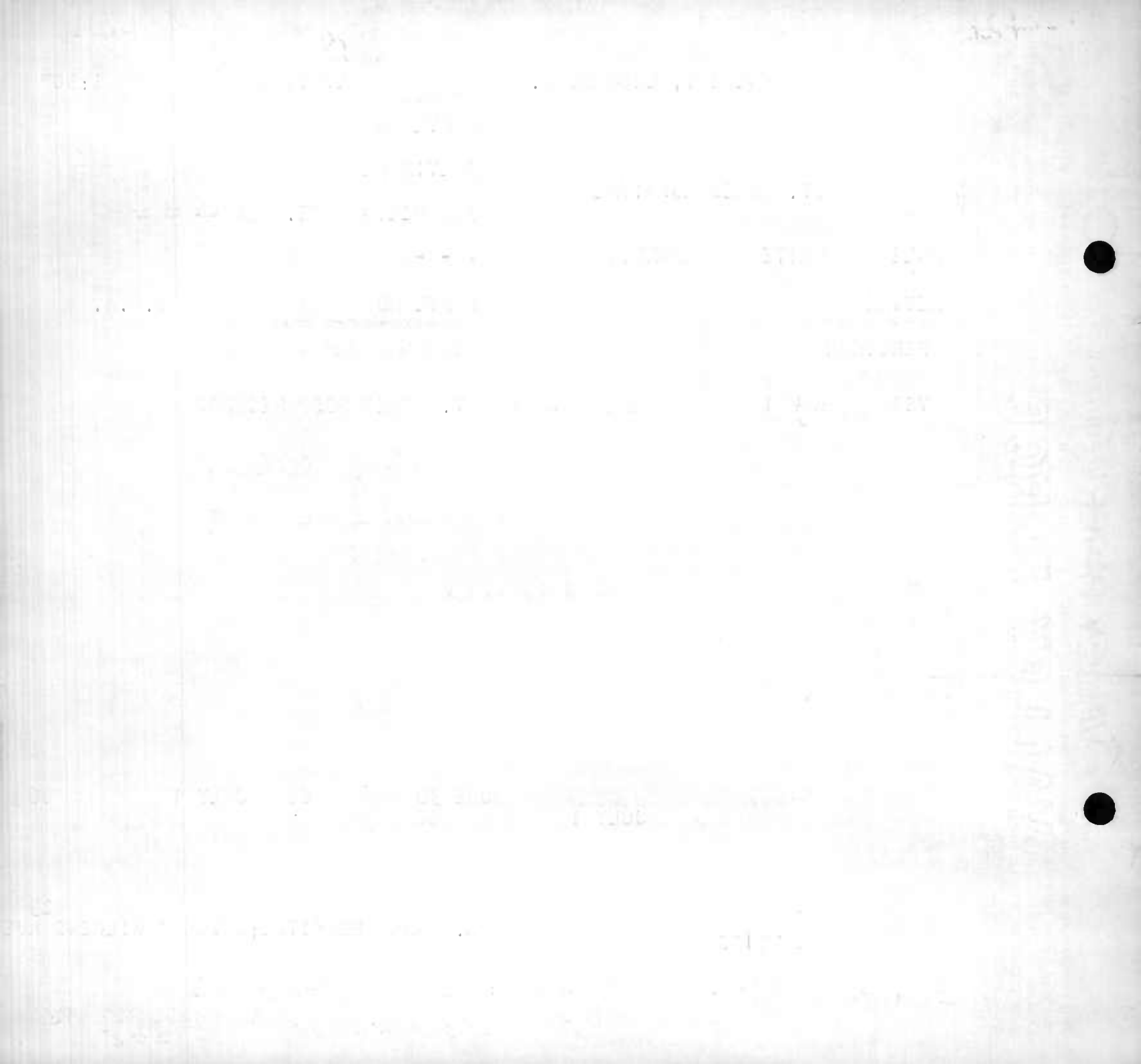
John T. Christell
John T. Christell

6-30-22
1028 E. Church St.
Portland, Me.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06704		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06704	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		VOLKERT, LEONARD H.		JULY 1, 1966 1:30P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE B. COUNTY		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		BALTIMORE	
ST. AGNES HOSPITAL		D. STREET ADDRESS (If rural, give location)		309 HILTON AVE. #28	
6. SEX MALE	7. RACE WHITE	8. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	9. DATE OF BIRTH 10-3-95	10. AGE (In years lost birthday) 70	11. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FERDINAND		14. MOTHER'S MAIDEN NAME JOHANNA LEINHAAS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 1		16. SOCIAL SECURITY NO. 212 014843		17. INFORMANT ADDRESS ST. AGNES HOSP RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Respiratory Acidosis (B) DUE TO Chronic Obstructive Lung Disease (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		H ASCVD			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 30 19 66 to JULY 1 19 66, that (I) (we) last saw the deceased alive on JULY 1 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) E WEISS		23D. ADDRESS ST. AGNES HOSPITAL; CATON & WILKENS AVE		#29	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/5/66		24C. NAME of CEMETERY or CREMATORY BALTO NATIONAL	
24D. LOCATION BALTO, MD.		25A. DATE RECEIVED BY HEALTH DEPT. 7/5/66		25B. NAME OF REGISTRAR E. J. Berkley	
25C. FUNERAL DIRECTOR F. S. MACNABB		25D. ADDRESS 301 FREDERICK RD		25E. CITY BALTO, MD.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 06705				
BIRTH NO. 66 06705									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) YOUNG ALBERT LOUIS					2. DATE AND HOUR OF DEATH 7-1-66 12:15 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 10 ST AGNES HOSPITAL					A. STATE MARYLAND B. COUNTY Baltimore				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00				
					D. STREET ADDRESS (If rural, give location) 4802 WESTLAND BLVD APT A				
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 5-26-13		9. AGE (In years last birthday) 53	
								If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor					10B. KIND OF BUSINESS OR INDUSTRY Clothing				
13. FATHER'S NAME STANLEY Young					14. MOTHER'S MAIDEN NAME HELEN Poudjumas				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II					16. SOCIAL SECURITY NO. 213-23-2979				
					17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					19. CAUSE OF DEATH (R) Lower lobe pneumonia Bronchectasis				
20. INTERVAL BETWEEN ONSET AND DEATH									
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
22. 19A. DATE OF OPERATION 21					22. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
23. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					24. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
25. 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)					26. 21E. INJURY OCCURRED While At Work [] Not While At Work []				
27. 21F. HOW DID INJURY OCCUR?					28. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
29. 22. I certify that (I) (this hospital) attended the deceased from JUNE 29 1966 to JULY 1 1966, that (I) (we) last saw the deceased alive on JULY 1 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					30. 23A. SIGNATURE M. HEREDIA				
31. 23B. DATE SIGNED JULY 1 1966					32. 23C. PHYSICIAN'S NAME (Type) M HEREDIA				
33. 23D. ADDRESS CATON & WILKENS AVE. BALTIMORE MD					34. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial				
35. 24B. DATE JUL 5 1966					36. 24C. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery				
37. 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					38. 25A. DATE REC'D BY HEALTH DEPT. 7-2-66				
39. 25B. NAME OF REGISTRAR 2. H. H. H.					40. 25C. FUNERAL DIRECTOR ADDRESS Ambrose Inc. 1328 Sulphur Sp. Rd.				

ST. JAMES AND HILL

WHITE LINE

WHITE LINE

28 OCTOBER 1941

WHITE LINE

1941

WHITE LINE

WHITE LINE

WHITE LINE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

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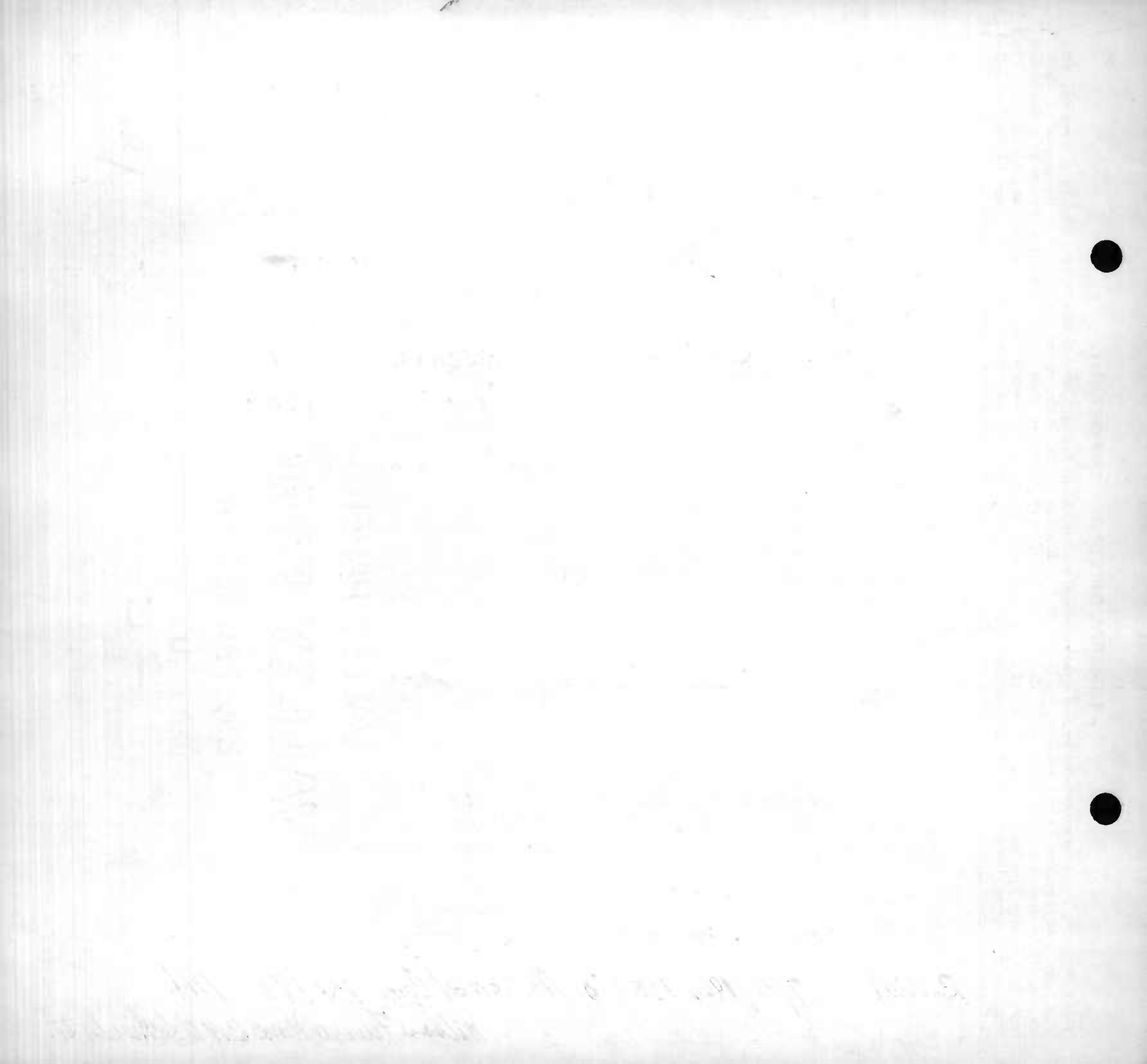
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

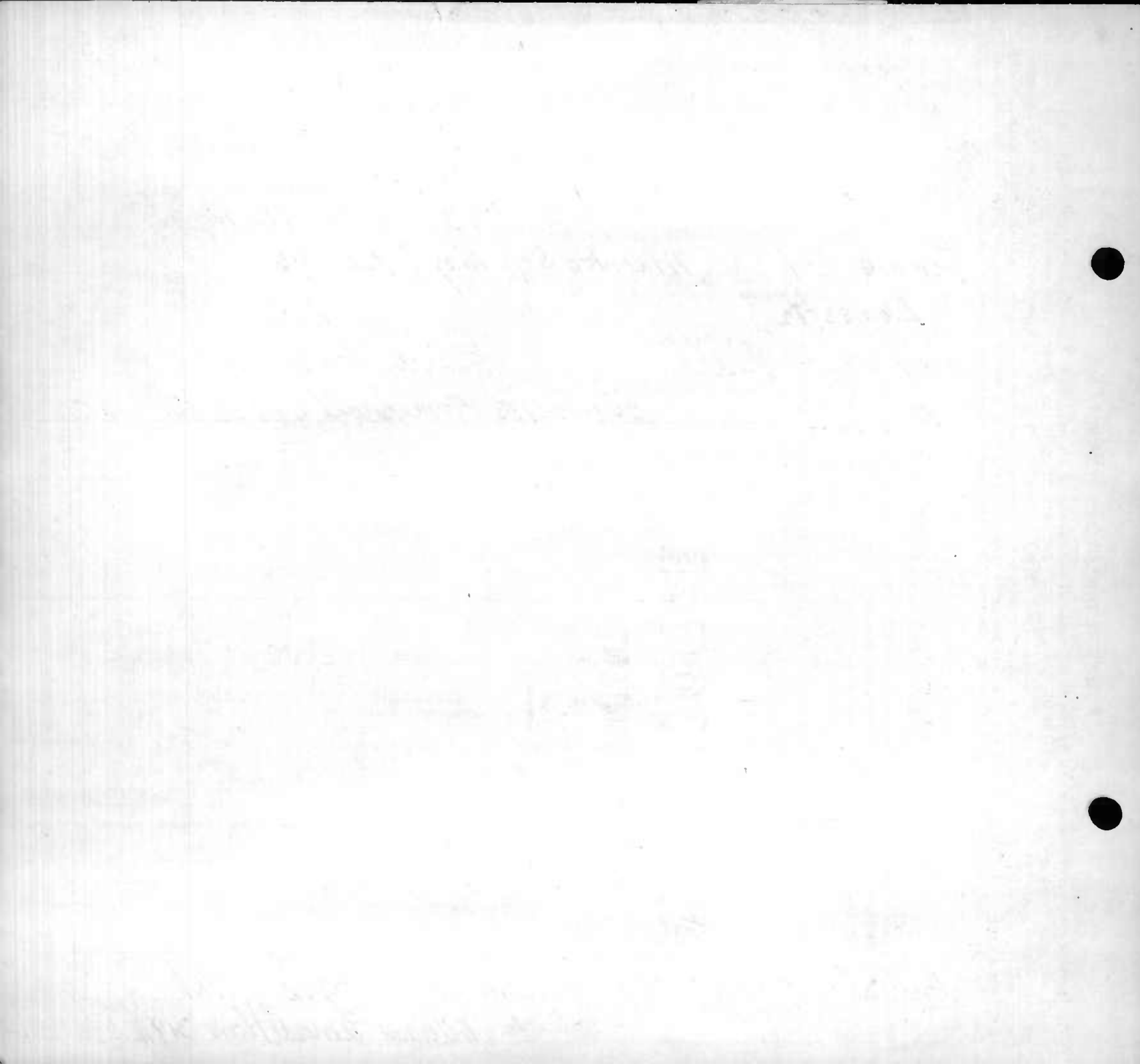
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06707</u>	
BIRTH NO. <u>66 06707</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BEULAH CHICHESTER</u>		2. DATE AND HOUR OF DEATH <u>7-1-66</u> <u>6:45 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>16-06</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MUNTEBELLO STATE HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>719 N. LONGWOOD ST.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5-19-1923</u>	9. AGE (In years last birthday) <u>43</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>GOLDEN SMITH</u>		14. MOTHER'S MAIDEN NAME <u>ROSENA BROWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>HOSPITAL RECORD</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>175.01</u> CAUSE OF DEATH <u>CARCINOMA of OVARY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>7-1-1966</u> to <u>7-1-1966</u> , that (X) (we) last saw the deceased alive on <u>7-1-1966</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Irving L. Cooperstein</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-1-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Irving L. Cooperstein</u>		23D. ADDRESS <u>MUNTEBELLO STATE HOSPITAL, BALTO-MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/5/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Balto. National Cem.</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. NAME OF REGISTERAR <u>Robert E. Tuller</u>		24F. FUNERAL DIRECTOR <u>Williams Funeral Home 319 N. Schroeder St.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1966</u>		25B. ADDRESS <u>Williams Funeral Home 319 N. Schroeder St.</u>			



FUNERAL DIRECTOR: IMPORTANT

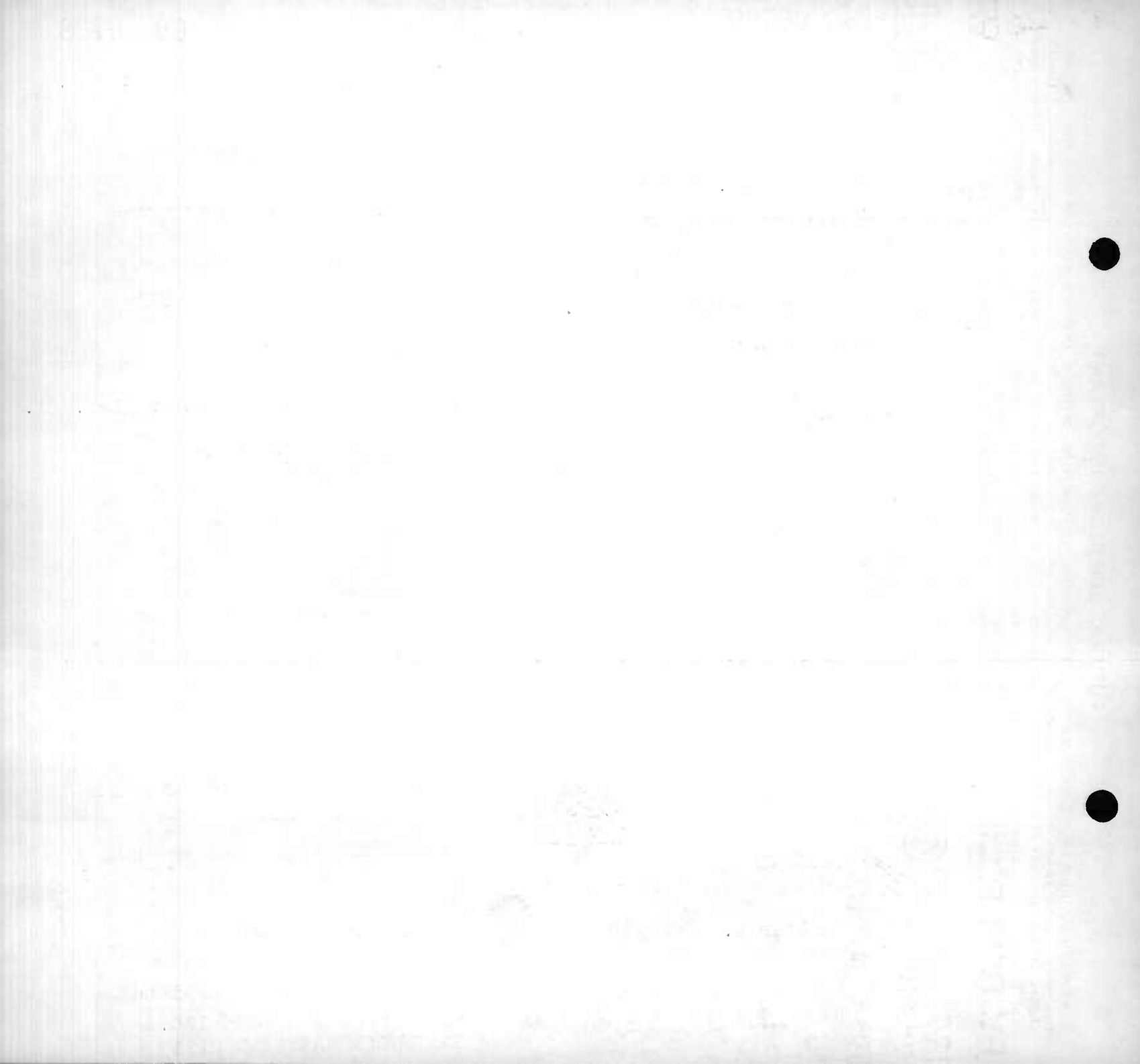
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06708		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66-6708	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PARKER, FANNIE		2. DATE AND HOUR OF DEATH 6-30-66 5:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 1602			
FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 639 N. Carrollton St.			
5. SEX Female	6. RACE Col.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married Sep	8. DATE OF BIRTH May 8 1920	9. AGE (In years last birthday) 46	10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Moore J. Britt		14. MOTHER'S MAIDEN NAME Willie Beaman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N		16. SOCIAL SECURITY NO. 264-12-6133		17. INFORMANT Rosa Scott 648 Peach Orchard Lane	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO C.V.A. (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 16 hrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-29-1966 to 6-30-1966, that (I) (we) last saw the deceased alive on 6-30-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ramon Suarez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-30-66	
23C. PHYSICIAN'S NAME (Type) RAMON SUAREZ		23D. ADDRESS M.D. Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/66		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D & HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Williams Funeral Home 319 N. Schroeder St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06709		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06709	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HARRY BAKER			2. DATE AND HOUR OF DEATH June 30, 1966 5:45 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1802 East 31st. Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218 D. STREET ADDRESS (If rural, give location) 1802 East 31st Street		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 22, 1891	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horse Trainer Retired 18 Yrs.			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME George Baker		
14. MOTHER'S MAIDEN NAME Emma Burkhardt			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 220 05 8334			17. INFORMANT Mrs Melba Baker 1802 East 31st. St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 5-27-1 I Pulmonary disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronary Heart Dis			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1945 to 6/30/66 19 that (I) (we) last saw the deceased alive on 6/30/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter E. Karfgin			23B. DATE SIGNED 7/1/66		
23C. PHYSICIAN'S NAME (Type) Walter E. Karfgin			23D. ADDRESS 4331 Harford Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/4/66		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC.			
25D. ADDRESS BALTIMORE MARYLAND 21213					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06710</u>	
BIRTH NO. <u>66 06710</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ANDREW JOHN SAUER</u>		2. DATE AND HOUR OF DEATH <u>JULY 1, 1966</u> <u>8.45 P. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>8-01</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21213</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Gould Convalesarium</u> <u>6116 Belair Road</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>2218 Pelham Avenue</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>Widower</u>	8. DATE OF BIRTH <u>Dec. 9. 1891</u>	9. AGE (In years lost birthday) <u>74</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Partner, Frank A. Sauer Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Mfrgr. Barrels</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Frank A. Sauer</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Muller</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-10-0992</u>		17. INFORMANT ADDRESS <u>Mrs. Jack B. Miller (Daughter)</u> <u>750 Kappock St. Riverdale N.Y. 10463</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac decompensation</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary Thrombosis - 1966</u> <u>Coronary Thrombosis - 1966</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 15,</u> 19 <u>66</u> to <u>July 1,</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 1,</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>J. Willis Guyton</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7/2/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. Willis Guyton</u>		23D. ADDRESS M.D. <u>3961 Greenmount Avenue</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>July 6. 1966</u>	24C. NAME OF CEMETERY or CREMATORY <u>Most Holy Redeemer</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Henry Sander & Sons Inc.</u> <u>Baltimore Maryland</u>	

K-230 66 06711

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 06711

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GAY KIGHT

2. DATE AND HOUR PRONOUNCED DEAD

2 July 1966

9:05 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

28-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5616 E. Stonington Ave.

5. SEX

female

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

1-3-49

9. AGE (In years
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Earl C. Kight

14. MOTHER'S MAIDEN NAME

Ruth Herforth

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

Earl C. Kight 5616 E. Stonington Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Cervical spinal cord compression
DUE TO

(C) Fracture of cervical vertebrae

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Woodlawn Drive and Gwynn Oak Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

June 27, 1966 3:11 p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

passenger on motorcycle in
motorcycle-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/3/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

7-6-66

23C. NAME OF CEMETERY or CREMATORY

Loudon Park

XXXXXX Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

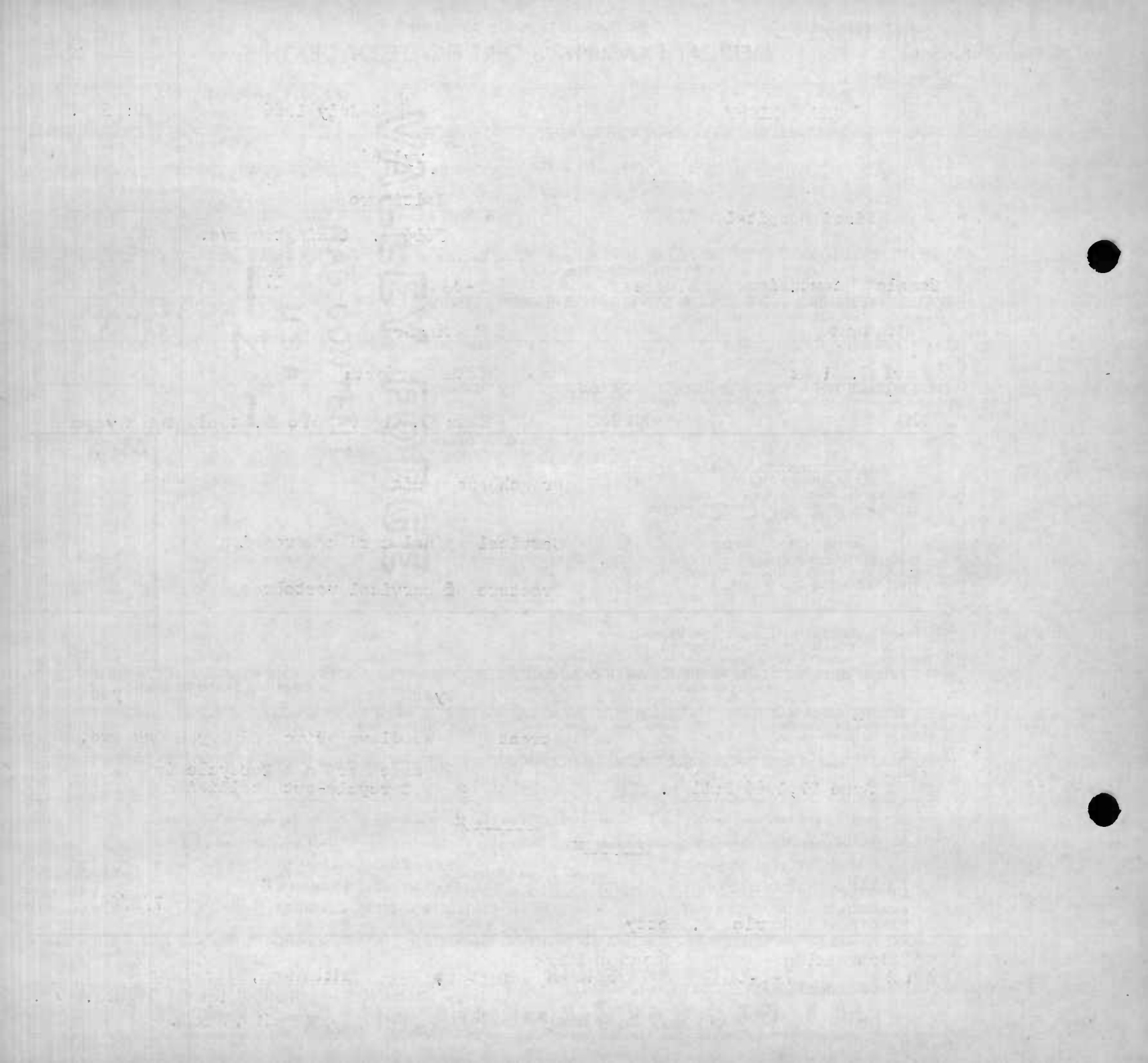
24C. FUNERAL DIRECTOR

4600 Liberty Hgts. Ave.
Balto, 7 Md.

JUL 5 1966

Robert E. Farkas

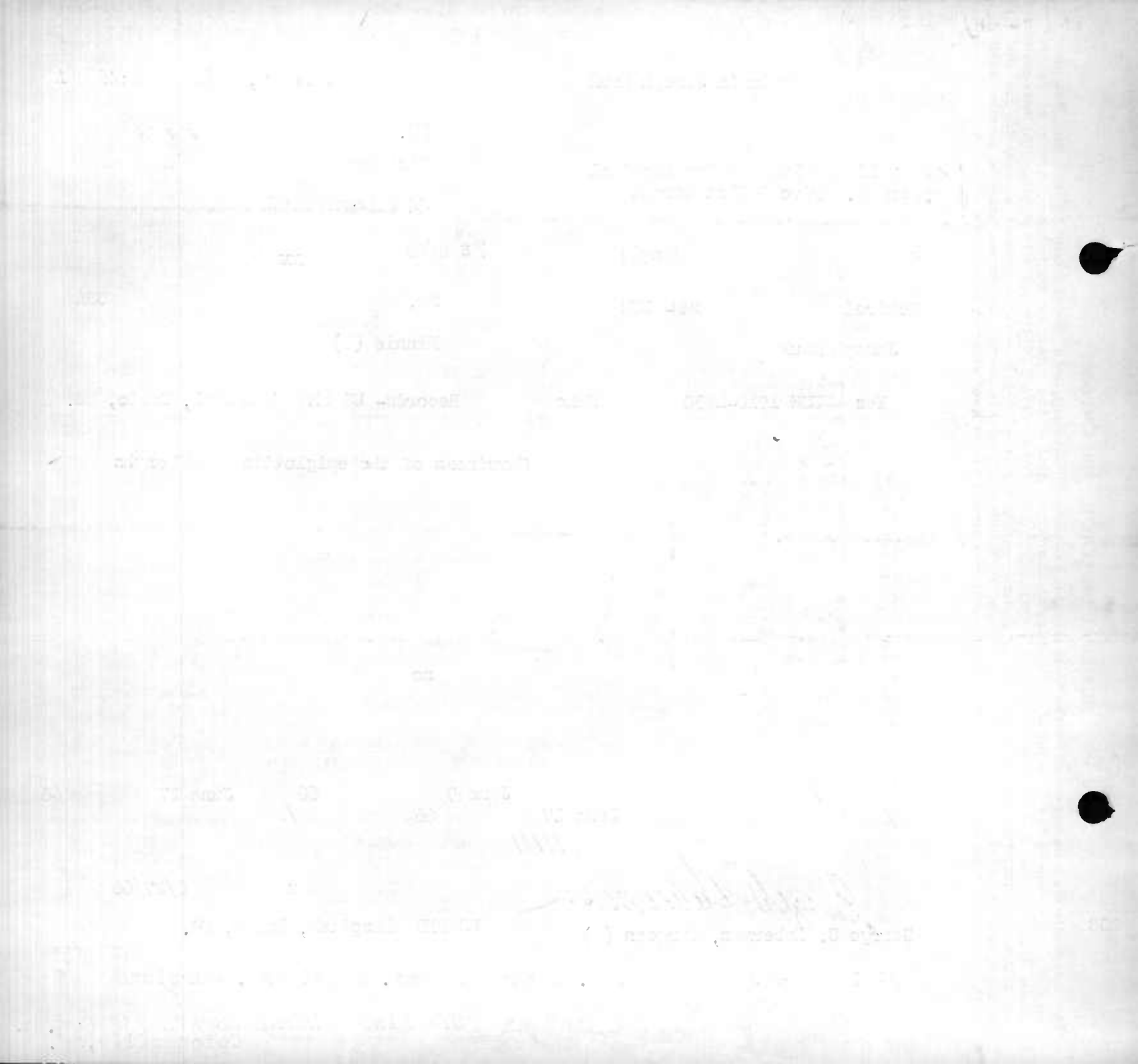
Ellsworth



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>66 06712</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>66 06712</u> CERTIFICATE OF DEATH </div>											
1. NAME OF DECEASED (Type or Print) <u>Benjamin Joseph Mauk</u>						2. DATE AND HOUR OF DEATH <u>June 27, 1966</u> <u>5:45</u> A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>US Public Health Service Hospital</u> <u>Wyman Pk. Drive & 31st Street</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Pasadena</u> D. STREET ADDRESS (If rural, give location) <u>44 Johnson Road</u>					
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u>		8. DATE OF BIRTH <u>7/6/88</u>		9. AGE (In years last birthday) <u>77</u>		If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>CMM- USN</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Joseph Mauk</u>						14. MOTHER'S MAIDEN NAME <u>Minnie (?)</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>USN 1910-1930</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Records- US PHS Hospital, Balto, Md.</u>					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of the epiglottis</u> (A) DUE TO _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO _____ (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
MEDICAL CERTIFICATION											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>June 9</u> <u>19 66</u> to <u>June 27</u> <u>19 66</u> , that (1) (we) last saw the deceased alive on <u>June 27</u> <u>19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>George G. Haberman</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>										23B. DATE SIGNED <u>6/27/66</u>	
23C. PHYSICIAN NAME <u>George G. Haberman, Surgeon (R)</u>				23D. ADDRESS <u>US PHS Hospital, Balto, Md.</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>30 June 66</u>		24C. NAME of CEMETERY or CREMATORY <u>Balto. National Cent.</u>				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1966</u>				25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>				25C. FUNERAL DIRECTOR ADDRESS <u>STERLING FUNERAL ESTATE 736 Edm. Au Catonsville, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06713		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06713	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Frank E. Sass.		2. DATE AND HOUR OF DEATH 7-1-66 1:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 24-04		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.		D. STREET ADDRESS (If rural, give location) 1506 Riverside Ave.			
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH 3-30-1896	9. AGE (in years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY None.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Julius		14. MOTHER'S MAIDEN NAME Martina Gpblz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT Family NAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Pulmonary embolism Thrombophlebitis Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. unknown unknown	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) state the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis, generalized Cerebral arterial insufficiency Fractured ribs & lumbar vertebrae			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1506 Riverside Ave	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) May 17 1966 ?		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Patient fell at home	
22. I certify that (this hospital) attended the deceased from 5-17 1966 to 7-1 1966, that (we) last saw the deceased alive on 7-1 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David M. Langdon		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-1-66	
23C. PHYSICIAN'S NAME (Type) David Langdon M.D.		23D. ADDRESS South Baltimore General Hosp.			
24A. BURIAL, CREMATION, REMOVAL (Specify) B		24B. DATE 7-5-66		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR McCurry - 130 E. Foster	
25D. ADDRESS					

(initials)

IN THE COURT OF THE DISTRICT OF COLUMBIA

Plaintiff, *Carroll M. Johnson*
vs.
Defendant, *Thompson*

Before me, the undersigned authority, on this day personally appeared *Carroll M. Johnson*, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this *17th* day of *May* 19*17*.

Notary Public

Carroll M. Johnson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06714	
BIRTH NO. 66 06714		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Joseph Lhotsky		2. DATE AND HOUR OF DEATH June 29, 1966 4:05 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-02			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1105 E. Fayette Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2400 E. Madison St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-21-1883	9. AGE (In years last birthday) 83	(If Under 1 Yr. Months Days) (If Under 24 Hrs. Hours Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retailer		10B. KIND OF BUSINESS OR INDUSTRY Produce Store		11. BIRTHPLACE (State or foreign country) Austria	
13. FATHER'S NAME Joseph Lhotsky		14. MOTHER'S MAIDEN NAME Francis Kuzel		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Marie Tye 2400 E. Madison St.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None		CAUSE OF DEATH (A) Cerebral Thrombosis DUE TO (B) arteriosclerotic Cardiovascular Disease DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 9 months 20 years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (XXX XXX) attended the deceased from Aug 18, 1965 to June 29, 1966 , that (I) (was) last saw the deceased alive on June 29, 1966 and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (XXX) view the body after death.					
23A. SIGNATURE Stanley Z. Felberberg				23B. DATE SIGNED 6/29/66	
23C. PHYSICIAN'S NAME (Type) STANLEY Z. FELBERBERG		23D. ADDRESS M.D. 1129 E. Baltimore St. Baltimore 2, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/66		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE RECEIVED BY HEALTH DEPT. JUL 5 1966			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Couch Funeral Home per E. J.			

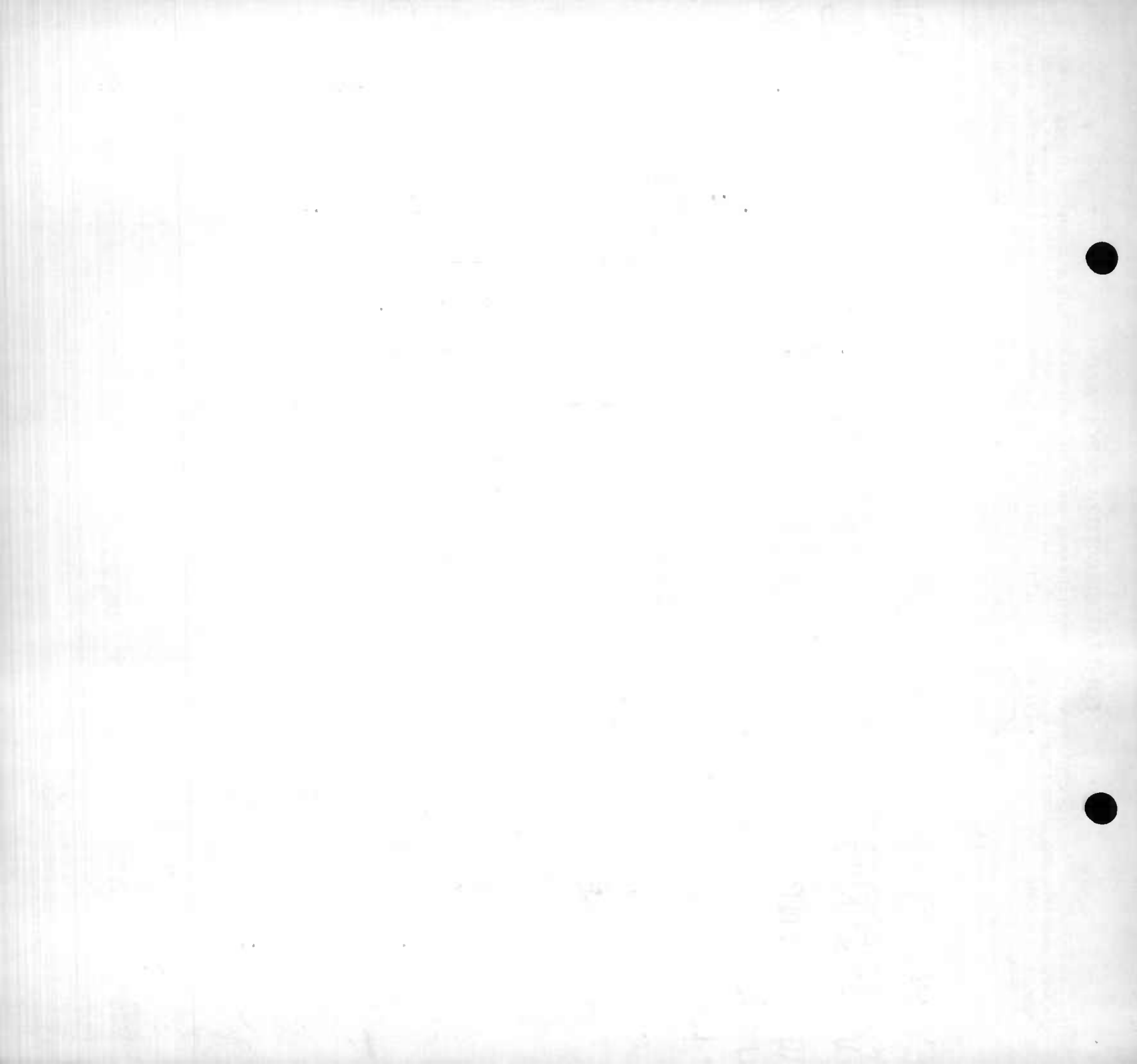
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1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 26

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

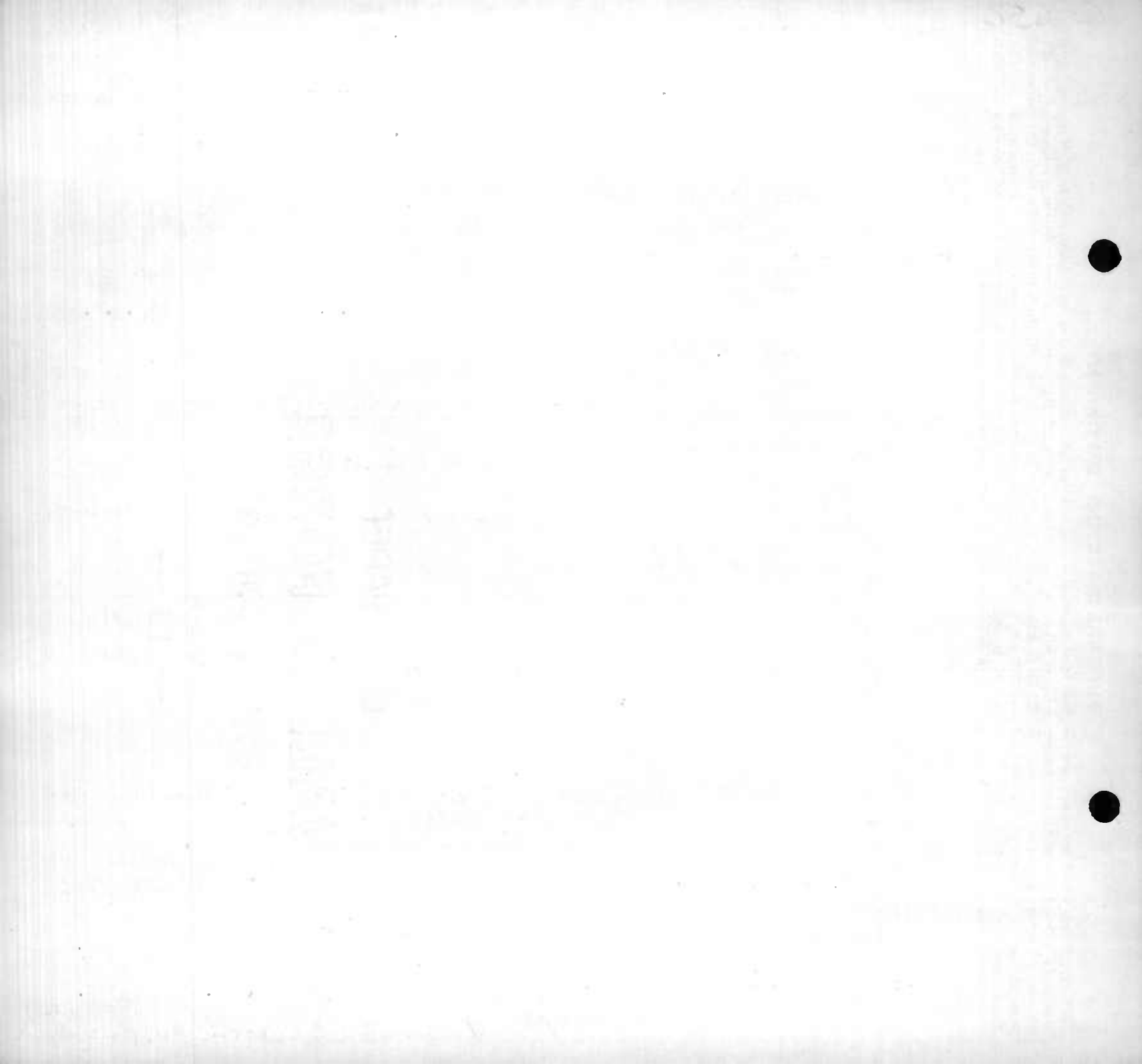
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06715</u>	
BIRTH NO. <u>66 06715</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Jessie L. Heath</u>			2. DATE AND HOUR OF DEATH <u>6-29-66</u> <u>3:00</u> am M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Little Sisters of the Poor</u> <u>1200 Valley St.</u> <u>Baltimore Md. 21202</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>10-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1200 Valley St.,</u>		
5. SEX <u>m</u>	6. RACE <u>w</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>separated</u>	8. DATE OF BIRTH <u>7-8-1891</u>	9. AGE (In years lost birthday) <u>75</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Richmond Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Jessie F. Heath</u>			14. MOTHER'S MAIDEN NAME <u>Annie Jackson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-09-5208</u>	17. INFORMANT ADDRESS <u>Little Sisters of the Poor</u>		
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <u>Acute Myocardial Infarction</u> DUE TO <u>A. S. C. V. D.</u> (B) <u>Generalized arteriosclerosis</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>June 29</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>June 29</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley Ankudas</u> M.D.			23B. DATE SIGNED <u>6.30.66.</u>		
23C. PHYSICIAN'S NAME (Type) <u>Stanley Ankudas</u>			23D. ADDRESS <u>1802 W. Baltimore St.,</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cathedral</u>	
24D. LOCATION <u>Baltimore</u>		24E. NAME OF REGISTRAR <u>Robert E. Taylor, JR</u>		24F. FUNERAL DIRECTOR <u>Philip Herwig Sons</u>	
25A. DATE REC'D JUL 5 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS <u>2024</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

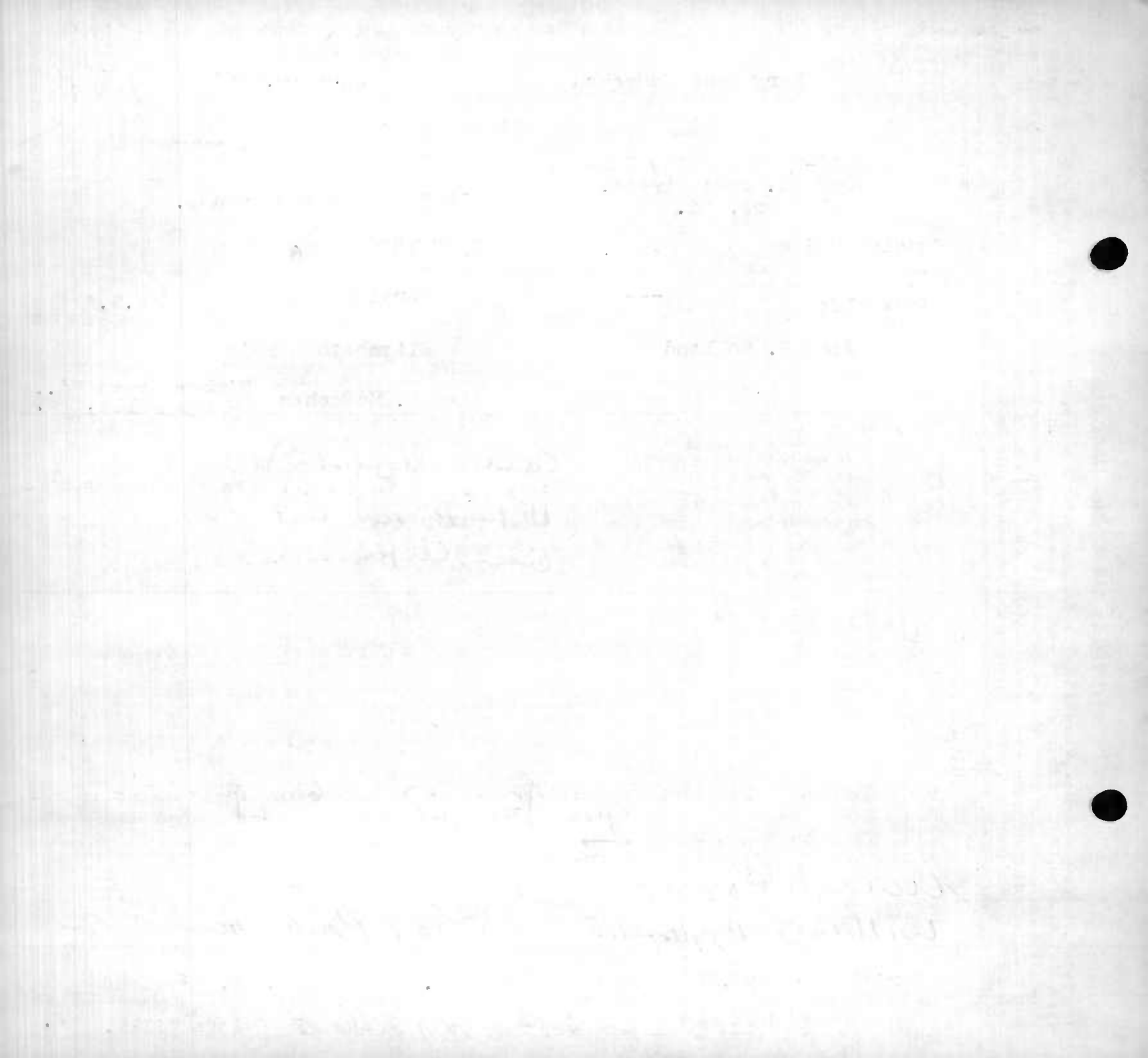
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06716	
BIRTH NO. 66 06716		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Clarence M. Crim		2. DATE AND HOUR OF DEATH 6-30-1966 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 27-05			
FULL NAME OF HOSPITAL OR INSTITUTION 3713 Pinewood Avenue		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3713 Pinewood Avenue #6			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-11-1903	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Maker		10B. KIND OF BUSINESS OR INDUSTRY Western Electric		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Clarence N. Crim		14. MOTHER'S MAIDEN NAME Elizabeth Myers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-9706		17. INFORMANT ADDRESS Mrs Magdalene Crim 3713 Pinewood Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 153.3 I		CAUSE OF DEATH (A) Metastatic Carcinoma DUE TO (B) Carcinoma of sigmoid DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 15 months 24 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0 3-22-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Sigmoid		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 4 19 47 to June 30 19 66 , that (I) (we) last saw the deceased alive on June 22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Adam G. Swiss		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 1, 1966	
23C. PHYSICIAN'S NAME (Type) Adam G. Swiss		23D. ADDRESS M.D. 6232 Belair Rd - 21206			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-2-1966	24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Co. Md.	
25A. DATE RECEIVED BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06717		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06717	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mary Emma McGeehan		2. DATE AND HOUR OF DEATH June 30, 1966 7:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. SEX Female	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mid-Town Nursing Home 808 St. Paul Street, Baltimore, Md.		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH 11/27/1879		9. AGE (In years last birt day) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME John G. Holland	
14. MOTHER'S MAIDEN NAME Elizabeth Barbie		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Alan L. McGeehan		ADDRESS Timber Grove Rd., Owings Mills, Md.		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 27, 1966 to June 30, 1966, that (I) (we) last saw the deceased alive on June 30, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William D. Boppfeld				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) William D. Boppfeld				23D. ADDRESS 5901 Park Heights Dr.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 4, 1966		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR H. J. Eckhardt		ADDRESS Owings Mills, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06718				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06718	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mahon, Stewart Franklin				2. DATE AND HOUR OF DEATH June 30, 1966 2:35 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-01			
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3646 Elm Ave 1604 Bolton Street			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/24/09	9. AGE (In years lost birthday) 57	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer		10B. KIND OF BUSINESS OR INDUSTRY Unknown Furniture		11. BIRTH PLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Mahon				14. MOTHER'S MAIDEN NAME Annie M. Myers			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 3/13/44-12/22/45		16. SOCIAL SECURITY NO. 215-03-83-63		17. INFORMANT Veterans Hospital Records Baltimore, Maryland 21218		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHIOGENIC CARCINOMA DUE TO Right Lower Lobe, Main Bronchus with Generalized Carcinomatosis INTERVAL BETWEEN ONSET AND DEATH 1 month							
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Mitral Valvulitis due to Rheumatic Heart Disease OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from June 20, 19 66 to June 30, 19 66 , that (2) (we) lost saw the deceased alive on June 30, 19 66 and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James F. Fries				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/30/66	
23C. PHYSICIAN'S NAME (Type) JAMES F. FRIES, M. D.				23D. ADDRESS VA Hospital, 3900 Loch Raven Blvd., Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4 Jul 66		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Fries		25C. FUNERAL DIRECTOR Burges Funeral Home 3631 Falls Rd Balto. Md		By: Walter H. Bengtson Jr	

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

EMIL ~~WENIGER~~ J. Weniger

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1966 12:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3215 N. Charles Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3215 N. Charles St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

July 10, 1905

9. AGE (In years
last birthday)

60

If Under 1 Yr. II Under 24 Hrs.
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Accountant

10B. KIND OF BUSINESS OR INDUSTRY

Manufacturing

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph N. Weniger

14. MOTHER'S MAIDEN NAME

Barbara Hack

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

215 05 6308

17. INFORMANT

Mrs. Marie McCormick, Washington, D. C.

ADDRESS

Massachusetts Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-29-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2 July 1966

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 5 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Burgess Funeral Home, 3631 Falls Rd., Balto. Md.

By:

Werner U. Spitz

WALL & CO. LTD.

100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

B. 625
W. 532

66 06720

BALTIMORE CITY HEALTH DEPARTMENT

66 06720

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLYDE H. BURKINS or Wentz

2. DATE AND HOUR PRONOUNCED DEAD

1 July 1966

7:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

918 Homestead St.

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2/3/1902

9. AGE in years
(last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Real estate

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George W. Wentz

14. MOTHER'S MAIDEN NAME

Erna A. Wentz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

212-09-0631

17. INFORMANT

ADDRESS

Mrs. Evelyn M. Burkins same address as above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/2/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/5/1966

23C. NAME of CEMETERY or CREMATORY

Meadowridge Mem. Pk. Cem.

23D. LOCATION

(City, town, or county)

(State)

Elkridge, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 5 1966

24B. NAME OF REGISTRAR

Robert E. ...

24C. FUNERAL DIRECTOR

Wm. J. ...

ADDRESS

WALTON FORGE

NO CONTENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06721		Registered No. 66 06721	
M.E. CASE NO. 66 06721				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				F. Stella I. Baum		July 2 1966 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE B. COUNTY	
F. NAME OF HOSPITAL OR INSTITUTION				Maryland		27-12	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
5842 Bellona Ave. 7/6/66				D. STREET ADDRESS (If rural, give location)		5842 Bellona Ave.	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Female		White		Widow		Feb. 5 1881	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own home		Ohio		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Howard Skiles				Sarah Renshaw			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Mr. John Miller as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		3 day s.	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from July 1 1966 to July 2 1966, that (I) (we) last saw the deceased alive on July 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Theodore J. Graziano M.D.						July 3, 1966	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Theodore J. Graziano				M.D. 2802 Hartford Rd 21218.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Removal		7/3/66		East Harrisburg		E. Harrisburg Penna.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 5 1966		Robert E. Fickel		Wm. J. Fickel & Sons		Baltimore	

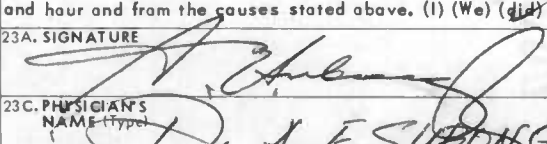
VSL53 7/6/66

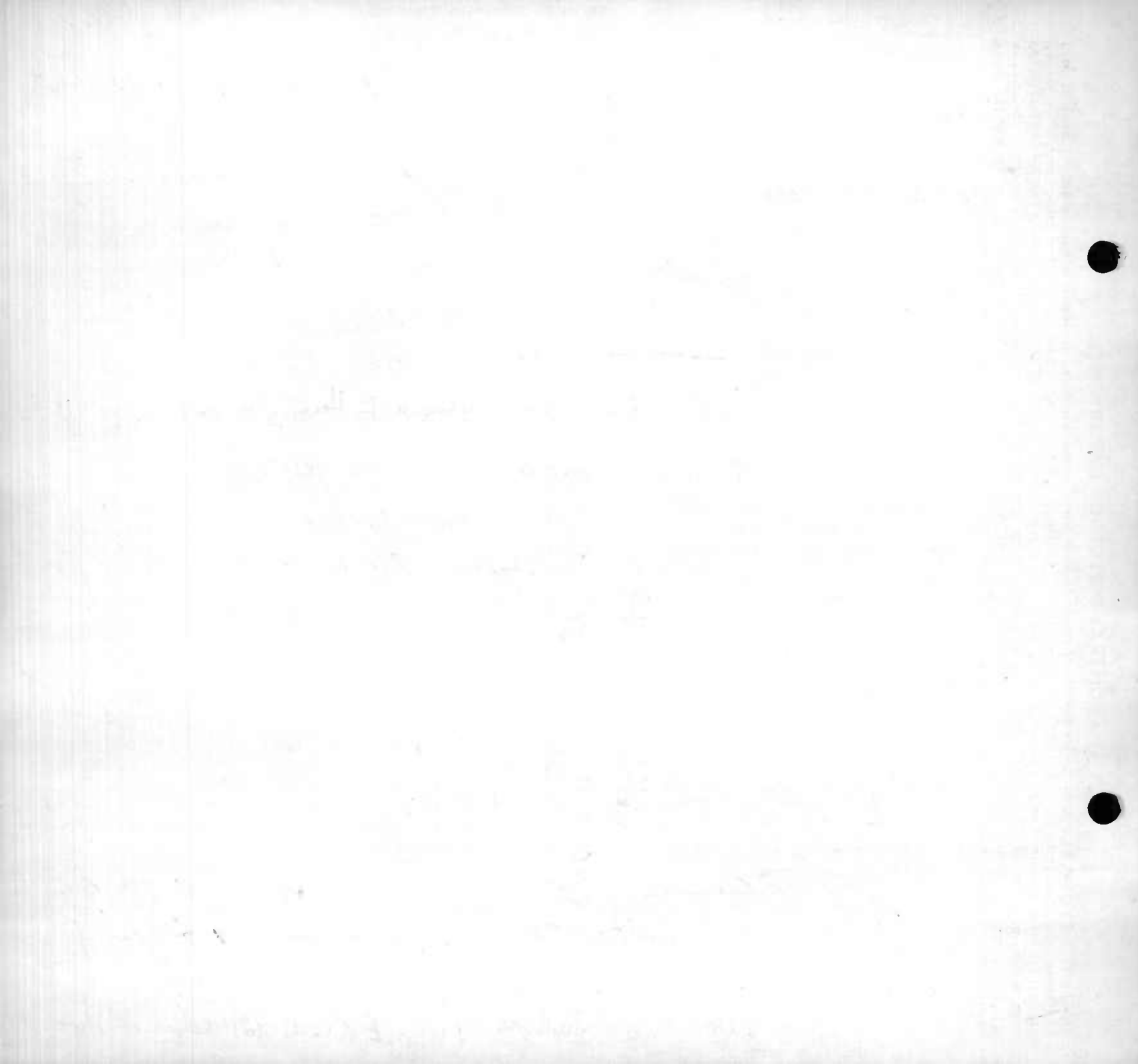
ORIGINAL AMENDED

Page 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06722		DEPARTMENT OF HEALTH		Registered No. 66 06722	
M.E. CASE NO. 147690			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) GRACE HENNING			2. DATE AND HOUR OF DEATH June 30, 1966 12:56 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE BALTO. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) 4607 Luerssen Ave. 27-01 D. STREET ADDRESS (If rural, give location) Baltimore		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-22-17	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME GEORGE STALLINGS MILKE			14. MOTHER'S MAIDEN NAME GRACE STALLINGS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-07-9660	17. INFORMANT ADDRESS Frederick E. Henning Sr. 4617 Luerssen Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive Heart Failure & Pleural Effusion			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 5-31-66 19 to 6-30 19 66 , that (I) (we) last saw the deceased alive on 6-30 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-30-66
23C. PHYSICIAN'S NAME (Type) Dr. A. E. SIMPSON, JR.			23D. ADDRESS Church Home & Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/2/66	24C. NAME OF CEMETERY OR CREMATORY OAK Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Philip E. Crach 1211 Chesaco Ave.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BALTIMORE CITY HEALTH DEPARTMENT	
66 06723				66 06723	
BIRTH NO.				Registered No.	
1. NAME OF DECEASED (Type or Print) DENNIS MANOS				2. DATE AND HOUR OF DEATH 7/3/66 620 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY X C. CITY OR TOWN (If outside city limits, write RURAL and give township) 312 MASON COURT D. STREET ADDRESS (If rural, give location) BALTIMORE 31,	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEP.	8. DATE OF BIRTH 8-15-88	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months Days Hours Min. 11
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EBAN		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS The Johns Hopkins Hospital Baltimore, Md.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarct. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD Severe CHF				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/30/66 19 66 to 7/3/ 19 66 , that (I) (we) last saw the deceased alive on 7/2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Taramaz Ismail Begi M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 7/3/66	
23C. PHYSICIAN'S NAME (Type) TARAMAZ Ismail-Begi				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL, BALTIMORE,	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/66		24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery	
24D. LOCATION (City, town or county) Baltimore, Md.		24E. LOCATION (State) MARYLAND		24F. LOCATION (Street) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Nicholas F. Matthews ADDRESS 3021 Eastern Ave., Baltimore, Md.	

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1/20/2014

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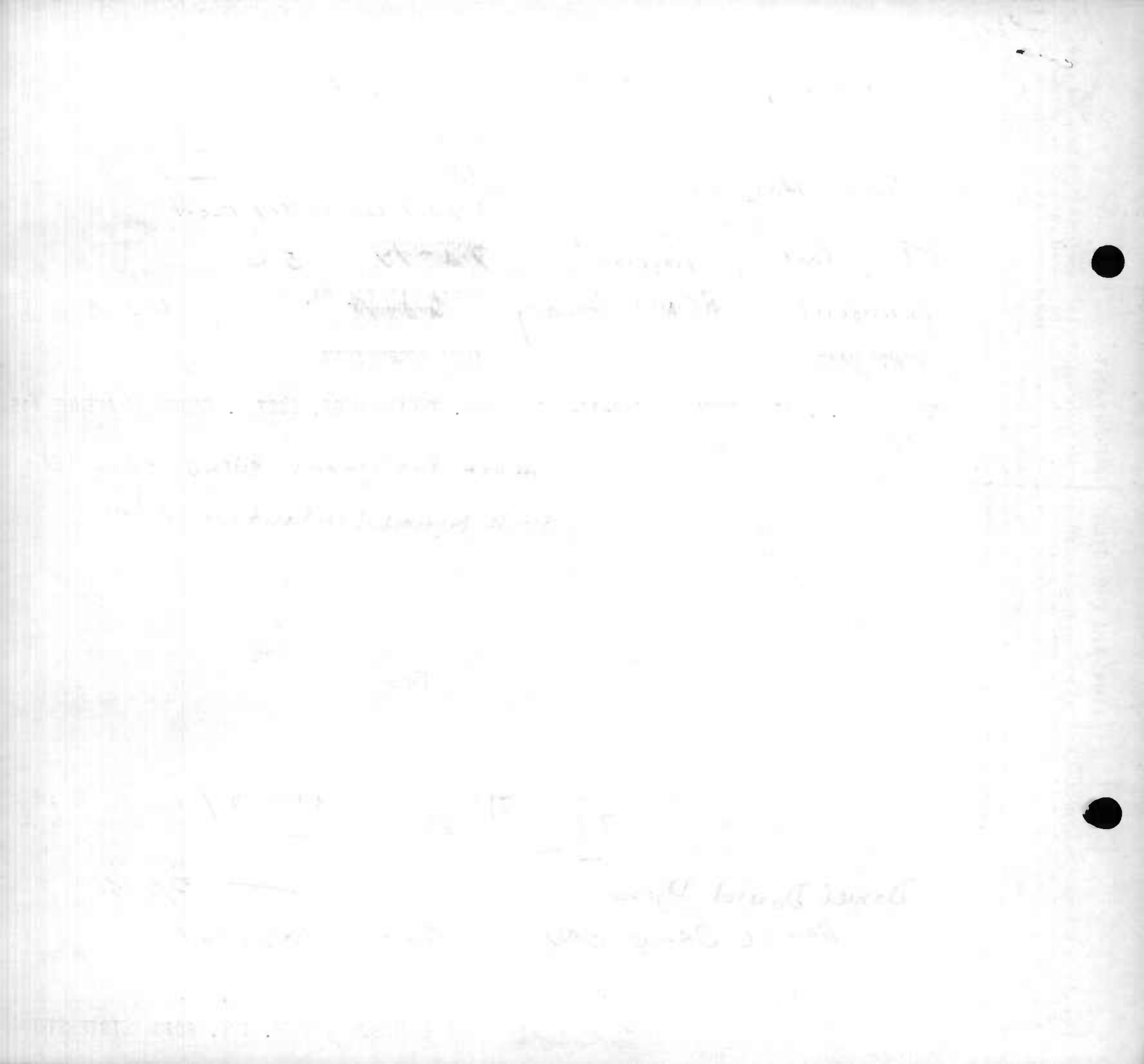
1/2/20

THOMAS J. JAMES - J-101
FORWARDING

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 06724					CERTIFICATE OF DEATH		Registered No. 66 06724		
1. NAME OF DECEASED (Type or Print) HAAZ ALFRED JACOB					2. DATE AND HOUR OF DEATH 7-1-66 4 40 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-17 D. STREET ADDRESS (If rural, give location) 2427 W. GARRISON				
5. SEX M	6. RACE Cauc.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH XXXXXXXXXX	9. AGE (In years lost birthday) 52	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist			10B. KIND OF BUSINESS OR INDUSTRY REAR'S Pharmacy		11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FRANK HAAZ					14. MOTHER'S MAIDEN NAME LENA ROSENSTEIN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. 11 ARMY -			16. SOCIAL SECURITY NO. 160-10-3418		17. INFORMANT ADDRESS MRS. THELMA HAAZ, 2427 W. GARRISON AVENUE #15				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I ACUTE PULMONARY edema estimated ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Myocardial infarction 2 hrs.					INTERVAL BETWEEN ONSET AND DEATH 2 hrs.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) 1(Month) 1(Day) 1(Year) 1(Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7/1/1966 to 7/1/1966 , that (I) (we) last saw the deceased alive on 7/1/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Daniel David Bass M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 7/1/66				
23C. PHYSICIAN'S NAME (Type) DANIEL DAVID BASS M.D.					23D. ADDRESS Sinai Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/3/66		24C. NAME OF CEMETERY or CREMATORY MONTEFIORE		24D. LOCATION (City, town, or county) (State) PHILADELPHIA, PA.			
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Feilberg		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		ADDRESS 6010 REISTERSTOWN			



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 06725		CERTIFICATE OF DEATH		Registered No. 66 06725	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Roth Levin</u>			2. DATE AND HOUR OF DEATH <u>7-1-66</u> <u>4¹⁰</u> <u>A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Balto Inc</u> <u>Belvidere & Greenway Ave</u> <u>#15</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> D. STREET ADDRESS (If rural, give location) <u>3601 Galesburg Rd #15</u>		
5. SEX <u>Female</u>	6. RACE <u>Cauc.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>6/18/03</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>SIMON LEVIN</u>			14. MOTHER'S MAIDEN NAME <u>FANNIE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>MR. ALBERT ROSENSTADT</u> ADDRESS <u>2704 GEARTNER ROAD</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>443X I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>			CAUSE OF DEATH (A) <u>Cerebral Thrombosis</u> DUE TO (B) <u>Hypertensive Arteriosclerosis</u> DUE TO <u>Cardiovascular dis.</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>25 yrs</u>
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>6-29-1966</u> to <u>7-1-1966</u> , that (I) (we) last saw the deceased alive on <u>6-29-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley J. Blum</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7/1/66</u>
23C. PHYSICIAN'S NAME (Type) <u>STANLEY J. BLUM</u>			23D. ADDRESS <u>Same as #3.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/3/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>ANSHE EMINAHATZ CHAIN</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1966</u>			
25B. NAME OF REGISTRAR <u>Q. C. & S. Feldman</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN</u>			

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06726		CERTIFICATE OF DEATH		Registered No. 66 06726		
1. NAME OF DECEASED (Type or Print) <u>Weinberg, Regina G.</u>				2. DATE AND HOUR OF DEATH <u>6-30-66</u> <u>230</u> P.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 SINAI HOSP OF BALTO</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>14-02</u> D. STREET ADDRESS (If rural, give location) <u>1724 Eutaw Place</u>						
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH XXXXXXXXXX	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u> XXXXXXXXXX		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JACOB GICHNER</u>				14. MOTHER'S MAIDEN NAME <u>JOHANNA ENOCH</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>DR. MYER A. WEINBERG</u> XXXXXXXXXX				ADDRESS <u>1724 EUTAW PLACE</u>	
18. <u>420.141260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>DIABETES MELLITUS</u>				CAUSE OF DEATH (A) <u>ACUTE MYOCARDIAL INFARCT</u> DUE TO (B) <u>ASCVD</u> DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>		
19A. DATE OF OPERATION <u>none</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>					
22. I certify that (I) (this hospital) attended the deceased from <u>6-25-66</u> to <u>6-30-66</u> , that (I) (we) last saw the deceased alive on <u>6-30-66</u> 19 <u>66</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Harry M. Shalen</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <u>6-30-66</u>				
23C. PHYSICIAN'S NAME (Type) <u>SINAI</u>						23D. ADDRESS <u>SINAI</u>				
24A. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/3/66</u>		24C. NAME of CEMETERY or CREMATORY <u>BALTO. HEBREW CONG.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1966</u>			25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN</u>					

12th April 1951

Dear Sir

Reference is made

to your letter of

11th April 1951

in which you refer

to the fact that

the matter has been

referred to the

relevant

authorities

and it is hoped

that the result

will be satisfactory

Yours faithfully

12/4/51

12th April 1951

Dear Sir

Reference is made

to your letter of

11th April 1951

in which you refer

to the fact that

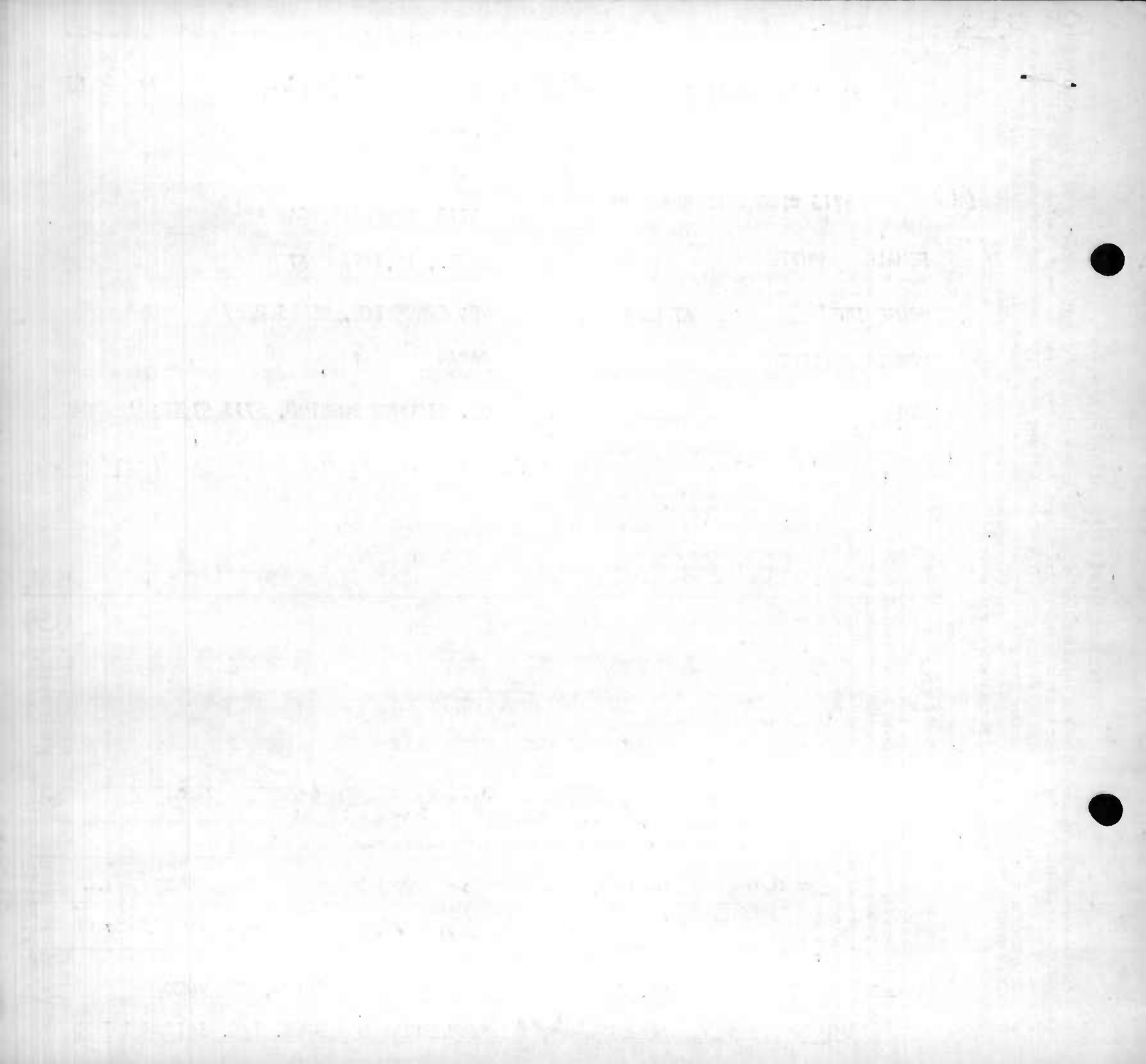
the matter has been

referred to the

FUNERAL DIRECTOR: IMPORTANT

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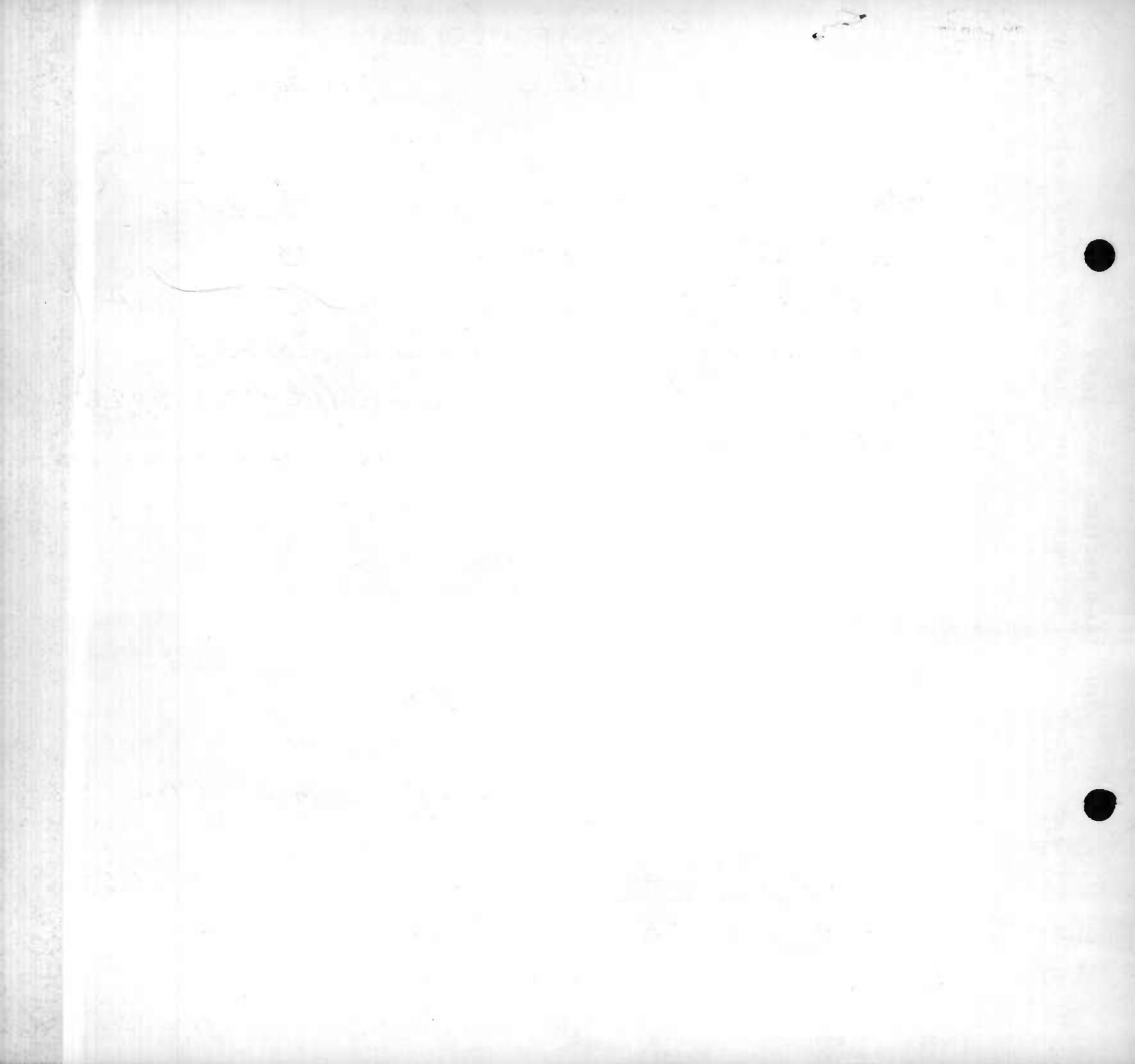
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 60 08727			
BIRTH NO. 05 08727										CERTIFICATE OF DEATH			
M.E. CASE NO.													
1. NAME OF DECEASED (Type or Print) NINA PHILIPS SUSKIND					2. DATE AND HOUR OF DEATH 7/1/66 4:15 A.M.								
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY								
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5713 RIDGEDALE ROAD #9					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE								
					D. STREET ADDRESS (If rural, give location) 5713 RIDGEDALE ROAD #9								
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW		8. DATE OF BIRTH SEPT. 10, 1898		9. AGE (In years last birthday) 67		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE					10B. KIND OF BUSINESS OR INDUSTRY AT HOME					11. BIRTHPLACE (State or foreign country) NEW BRUNSWICK, NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MORRIS PHILIPS					14. MOTHER'S MAIDEN NAME SARAH ?								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO.		17. INFORMANT DR. SIGMUND SUSKIND, 5713 RIDGEDALE ROAD #9					ADDRESS	
18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the uterus CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 4 years													
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.													
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from april 19 65 to July 1 19 66 , that (I) (we) last saw the deceased alive on June 30 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE Gordon Ceder M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>										23B. DATE SIGNED 7/1/66			
23C. PHYSICIAN'S NAME (Type) GORDON CEDER M.D.										23D. ADDRESS 611 Park Ave. - Balto. 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) burial			24B. DATE 7/3/66			24C. NAME OF CEMETERY or CREMATORY MT. JUDAH			24D. LOCATION (City, town, or county) (State) BROOKLYN, NEW YORK				
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966			25B. NAME OF REGISTRAR Robert E. Farley			25C. FUNERAL DIRECTOR ADDRESS SOLIEVINSON & BROS. INC. 6010 REISTERSTOWN							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

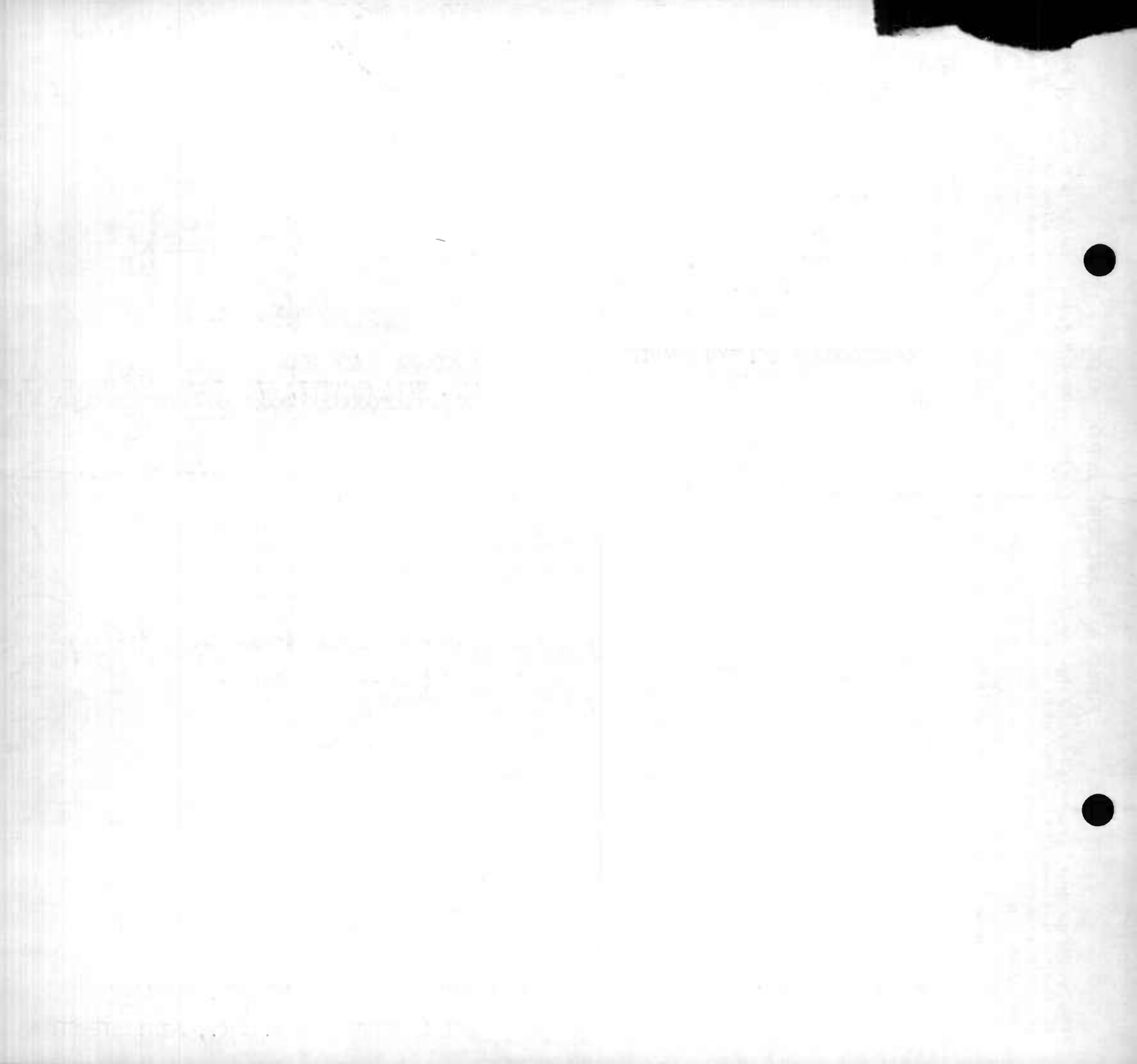
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 06728	
BIRTH NO. 66 06728		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Ada Hornstein</i>		2. DATE AND HOUR OF DEATH <i>June 30/66 9⁴⁵ P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Paeon Hall Nursing Home 4601 Paeon Hall Road</i>				A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>15-12</i>			
				D. STREET ADDRESS (If rural, give location) <i>2821 Hillside Ave</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>April 15, 1893</i>	9. AGE (In years, last birthday) <i>73</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>New York City</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Nathaniel Levy</i>			14. MOTHER'S MAIDEN NAME <i>Bessie Reichenbach</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Betty H. Raffel - 3408 Rippe Rd</i>		
18. <i>443 XI</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) <i>Coronary Vascular Accident</i>		<i>one week.</i>	
ANTECEDENT CAUSES				(B) <i>arteriosclerosis C.V.D.</i>		<i>3 years.</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <i>Hypertension</i>		<i>5 years.</i>	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/29 1959</i> to <i>6/30 1966</i> , that (I) (we) lost saw the deceased alive on <i>6/30 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>A. A. Silver</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7/1/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>A A SILVER</i>				23D. ADDRESS <i>Temple Garden Apts</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/1/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Hebrew Friendship</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE REC'D BY HEALTH DEPT <i>JUL 3 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Sal Leason & Ruth</i>		ADDRESS <i>6000 Reister Rd</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

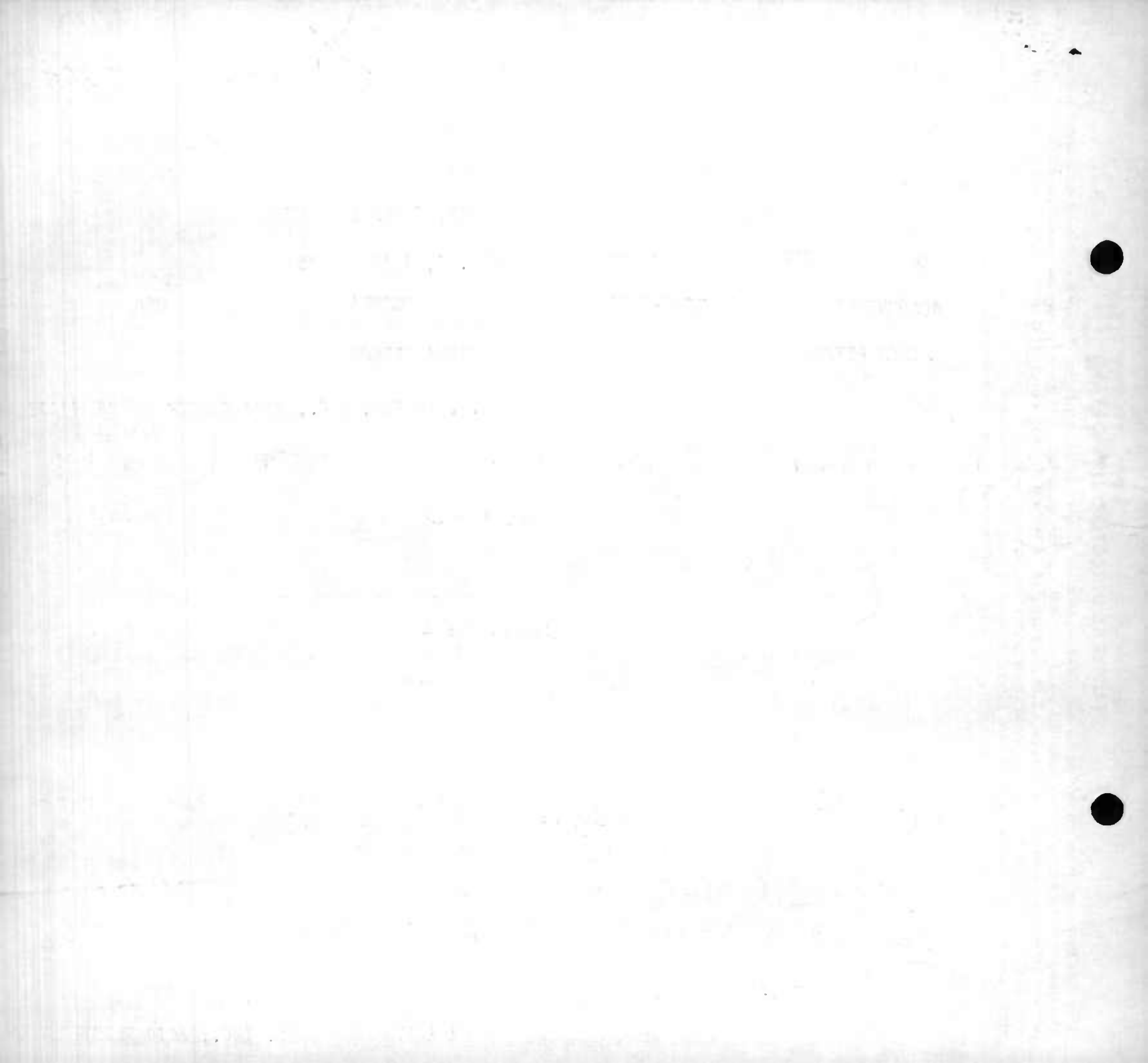
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 06729	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 66 06729 M.E. CASE NO. </div>							
1. NAME OF DECEASED (Type or Print) BARNEY SHAVITZ				2. DATE AND HOUR OF DEATH 30 JUNE 66 11:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6707 TOWNBROOK DRIVE #7			
5. SEX MALE	6. RACE CAUC.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-27-94	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY ANTIQUES, DEALER		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME XXXXXXXXXX SOLOMON SHAVITZ				14. MOTHER'S MAIDEN NAME XXXXXXXXXX ADA REVA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ?		17. INFORMANT MRS. RITA SHAVITZ ADDRESS 6707 TOWNBROOK DRIVE APT 7			
18. 7-22-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) cerebrovascular accident DUE TO to further extensive (B) arteriosclerotic cardiovascular disease DUE TO chronic (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH 10 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Acute upper gastrointestinal hemorrhage			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 20 , 19 66 to June 30 , 19 66 , that (I) (we) last saw the deceased alive on June 30 , 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Michael Levin				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Steno. Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 30, 1966	
23C. PHYSICIAN'S NAME (Type) MICHAEL LEVIN				23D. ADDRESS M.D. Sinai Hospital of Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/1/66		24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH AITZ CHAIM		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Fiedler		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 600 REISTERSTOWN			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 06730
CERTIFICATE OF DEATH										
BIRTH NO. 66 06730		M.E. CASE NO.								
1. NAME OF DECEASED (Type or Print) PITKIN, MOSES HENRY					2. DATE AND HOUR OF DEATH 7/1/66 - 7:20 AM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
					D. STREET ADDRESS (If rural, give location) 4030 JERUSALEM AVENUE					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH OCT. 1, 1890	9. AGE (In years lost birthday) 75		If Under 1 Yr. Months: Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10B. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME MALECH PITKIN				14. MOTHER'S MAIDEN NAME DISHA KIPSON						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS I. J. MORRIS, INC., 9701 CHURCH AVENUE 11212				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 72014-260X MYOCARDIAL INFARCTION DUE TO ASCVD INTERVAL BETWEEN ONSET AND DEATH SUDDEN YEARS										
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				DIABETES						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (1) (this hospital) attended the deceased from 6/23 19 66 to 7/1 19 66 , that (1) (we) lost saw the deceased alive on 6/30/66 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.										
23A. SIGNATURE B. R. Shochet, MD M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 7/1/66			
23C. PHYSICIAN'S NAME (Type) BERNARD R. SHOCHET				23D. ADDRESS 6804 PARK HEIGHTS AVE, BALTO-15, Md.						
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 7/3/66		24C. NAME OF CEMETERY or CREMATORY BETH MOSES		24D. LOCATION (City, town, or county) (State) PINELAWN, NEW YORK				
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN						



Dr. Spetz, M.D. Swoboda
MEDICAL EXAMINER NOTIFIED
FURNAL DIRECTOR: IMPORTANT
TO BE RELEASED BY THE CHIEF MEDICAL EXAMINER OR HIS ASSISTANT IF DEATH OCCURRED IN A HOSPITAL AND MEDICAL EXAMINER APPROVAL MEDICAL EXAMINER APPROVAL
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06731		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06731	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) BABICKI, JOANNA				June 29, 1966 12:00 noon M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
CHURCH HOME & HOSPITAL		MARYLAND			
		C. CITY OR TOWN (If outside city limits, give RURAL and give township)			
		BALTIMORE		2-01	
		D. STREET ADDRESS (If rural, give location)			
		309 S. WOLFE ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
F	WHITE	MARRIED	9/17/95	70	U.S.A
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		UNKNOWN		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
FRANCIS SZCZUBLEWSKI			ROSALIE TECHAU		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
E9030			Gam negative Septicemia?		
ANTECEDENT CAUSES			Complete A-U BLOCK		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Intercapsular fracture hip		
II			23 days		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
0					
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
			Home		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			309 S. Wolfe St. 2-01		
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		
6-6-66			While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			Getting up from chair		
22. I certify that (I) (this hospital) attended the deceased from June 6, 1966 to June 29, 1966, that (I) (we) last saw the deceased alive on June 29, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Manuel J. Tan					
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
MANUEL J. TAN			Church Home & Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7.4.66		Sacred Heart of Mary Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 5 1966		Robert E. Jenkins		Fred W. Ozagowski	
				ADDRESS	
				1930 Eastmore	

TO BE RETURNED TO THE NATIONAL ARCHIVES
BY THE NATIONAL ARCHIVES

FRANCIS 25 CTN BTFW2K1
KOSGASHE TFC + V. 12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06732		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06732	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HESTER JANE MILLER		2. DATE AND HOUR OF DEATH June 29, 1966 9:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rural - Freeland	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bolton Hill Nursing Home		D. STREET ADDRESS (If rural, give location) Middletown Rd.		5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH Oct. 14, 1873		9. AGE (In years, last birthday) 90		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Upperco, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Wilhelm		14. MOTHER'S MAIDEN NAME Edith Wilhelm	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 25-502645		17. INFORMANT Mrs. Edna Parrish, Freeland, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac failure		CAUSE OF DEATH Fracture left femur		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 17 May 66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fracture left hip		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore County	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 5-16-66		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Patient fell in home	
22. I certify that (I) (this hospital) attended the deceased from 16 May 1966 to 29 June 1966 , that (I) (we) last saw the deceased alive on 29 June 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.					
23A. SIGNATURE S. E. Proctor		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 29 June 66	
23C. PHYSICIAN'S NAME (Type) S. E. Proctor		23D. ADDRESS 104 N. Madison St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 2, 1966		24C. NAME OF CEMETERY or CREMATORY Lutheran Cemetery	
24D. LOCATION (City, town, or county) (State) Manchester, Carroll Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR J. J. Hartenstein		ADDRESS New Freedom, Pa.			

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BALTIMORE CITY HEALTH DEPARTMENT

66 06733

BIRTH NO. <u>61-08727</u>		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. <u>61-08727</u>
M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD	
DWAYNE LEE ARRINGTON			June 27, 1966 2:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY	
St. Agnes Hospital			Maryland CARROLL	
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
			Sykesville 56-00	
			D. STREET ADDRESS (If rural, give location)	
			MARIOTTSVILLE Rd.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	White	Single	March 27, 1961	5
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
			Maryland	U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME	
Wayne Arrington			Jacquelyn Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). If yes, give war or dates of service		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
No			Mr. Wayne Arrington - Sykesville, Md.	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO	
			Severe Confluent Bronchopneumonia.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO	
			(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		6/27/66
Charles S. Petty, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY
Burial		6-29-66		Springfield
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR
JUL 5 1966		Robert E. Finkbeiner		Harry W. Haight
				ADDRESS
				Sykesville, Md.

WILLIAMS

March 22 1941

Sample

Investigation

Wayne Livingston

Mr. Wayne Livingston

No.

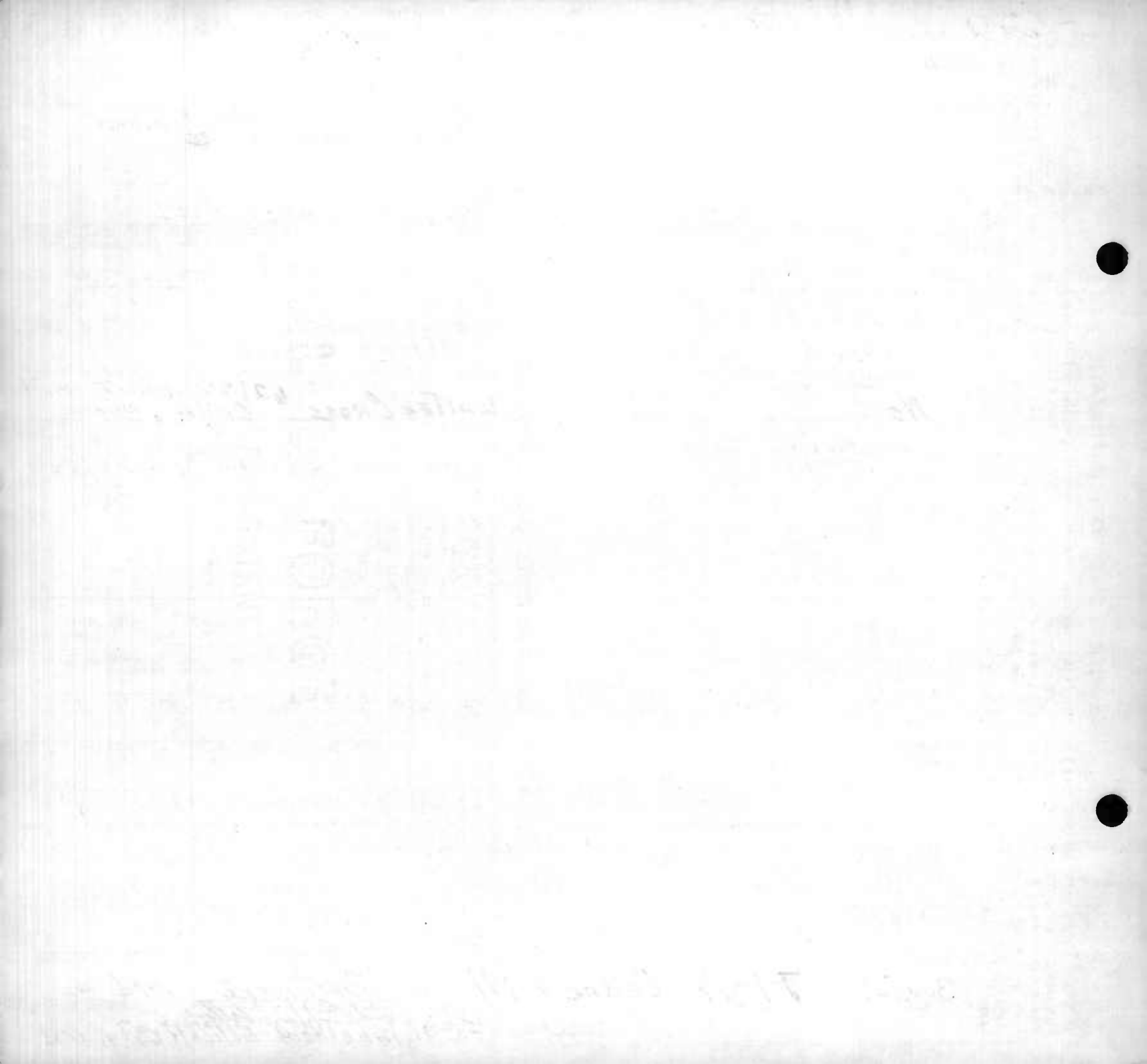
March 22 1941

Wayne Livingston

FUNERAL DIRECTOR: IMPORTANT

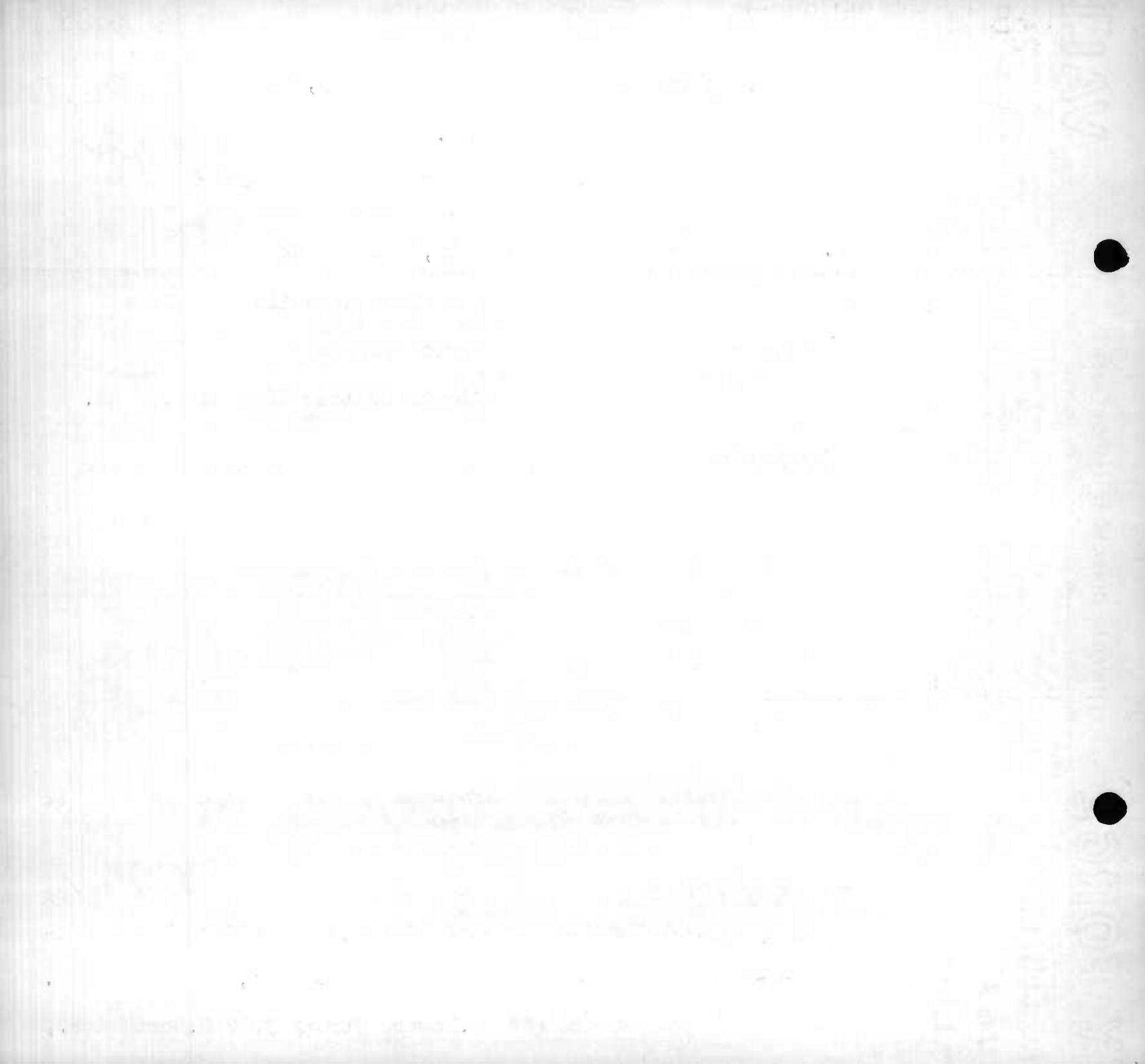
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06734		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06734	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MADELINE CROSS		2. DATE AND HOUR OF DEATH 6/27/66 6:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		A. STATE MD B. COUNTY BALTIMORE			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BELLA			
		D. STREET ADDRESS (If rural, give location) 621 PLEASANT HILL			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6/19/19	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME THOMAS SHAVER		14. MOTHER'S MAIDEN NAME ALICE MULLINS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT WAITER CROSS ADDRESS 621 PLEASANT HILL	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 452X1		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) ANTERIOR COMMUNICATING ANEURYSM		6/12/66	
ANTECEDENT CAUSES		(B) CEREBRAL EDEMA		141 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6/21/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CEREBRAL ANEURYSM		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/19 19 66 to 6/27 19 66 , that (I) (we) last saw the deceased alive on 6/27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald L. Paul				23B. DATE SIGNED 6/27/66	
23C. PHYSICIAN'S NAME (Type) RONALD L. PAUL				23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-1-66		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Baltimore MD		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR'S ADDRESS F.C. Higginbotham, Jr., 1100 E. Pratt St., Baltimore, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

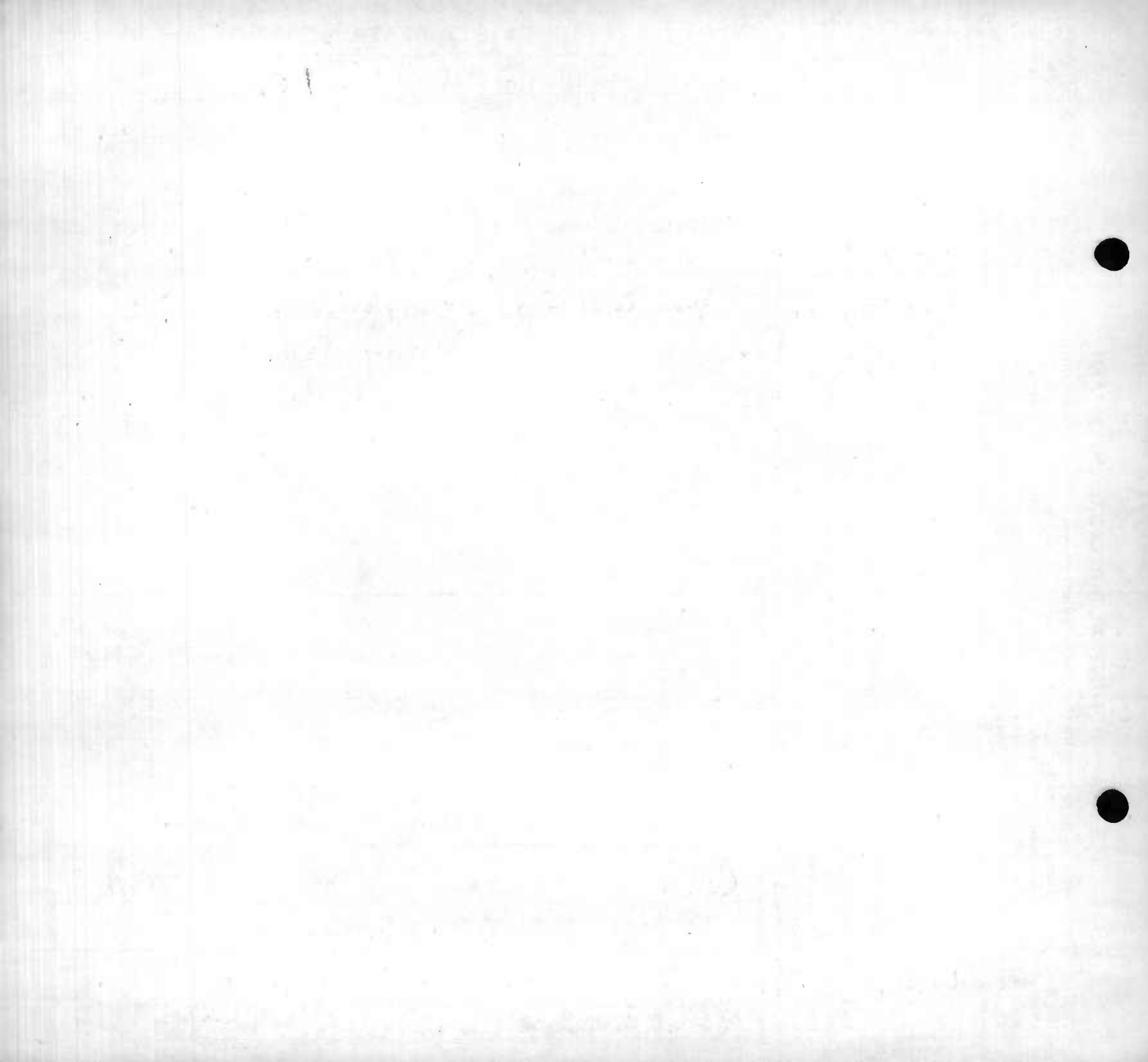
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 06735</u>	
BIRTH NO. <u>66 06735</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Cesar E. Pellerano</u>		2. DATE AND HOUR OF DEATH <u>June 29, 1966</u> <u>5:15 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>1028 Reverdy Road</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
D. STREET ADDRESS (If rural, give location) <u>1028 Reverdy Road</u>							
5. SEX <u>Male</u>	6. RACE <u>W.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widower</u>	8. DATE OF BIRTH <u>May 10, 1890</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Dominican Republic</u>		12. CITIZEN OF WHAT COUNTRY? <u>Cuba</u>	
13. FATHER'S NAME <u>Eduard Pellerano</u>				14. MOTHER'S MAIDEN NAME <u>Teresa Torres</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Alberto Santalo 1028 Reverdy Rd.</u>			
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> ANTECEDENT CAUSES <u>SENILE MELANCHOLIA</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (B) <u>SENILE MELANCHOLIA</u> DUE TO (C) _____			
INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>YEARS</u>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 10</u> 19 <u>66</u> to <u>JUNE 29</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>JUNE 29</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Luis J. Elias, M.D.</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>JUNE 30/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>LUIS J. ELIAS, M.D.</u>				23D. ADDRESS <u>1701 MERIDENE DR. BALTIMORE MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-2-1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>G. Howard Strong 3207 W. North Ave.,</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

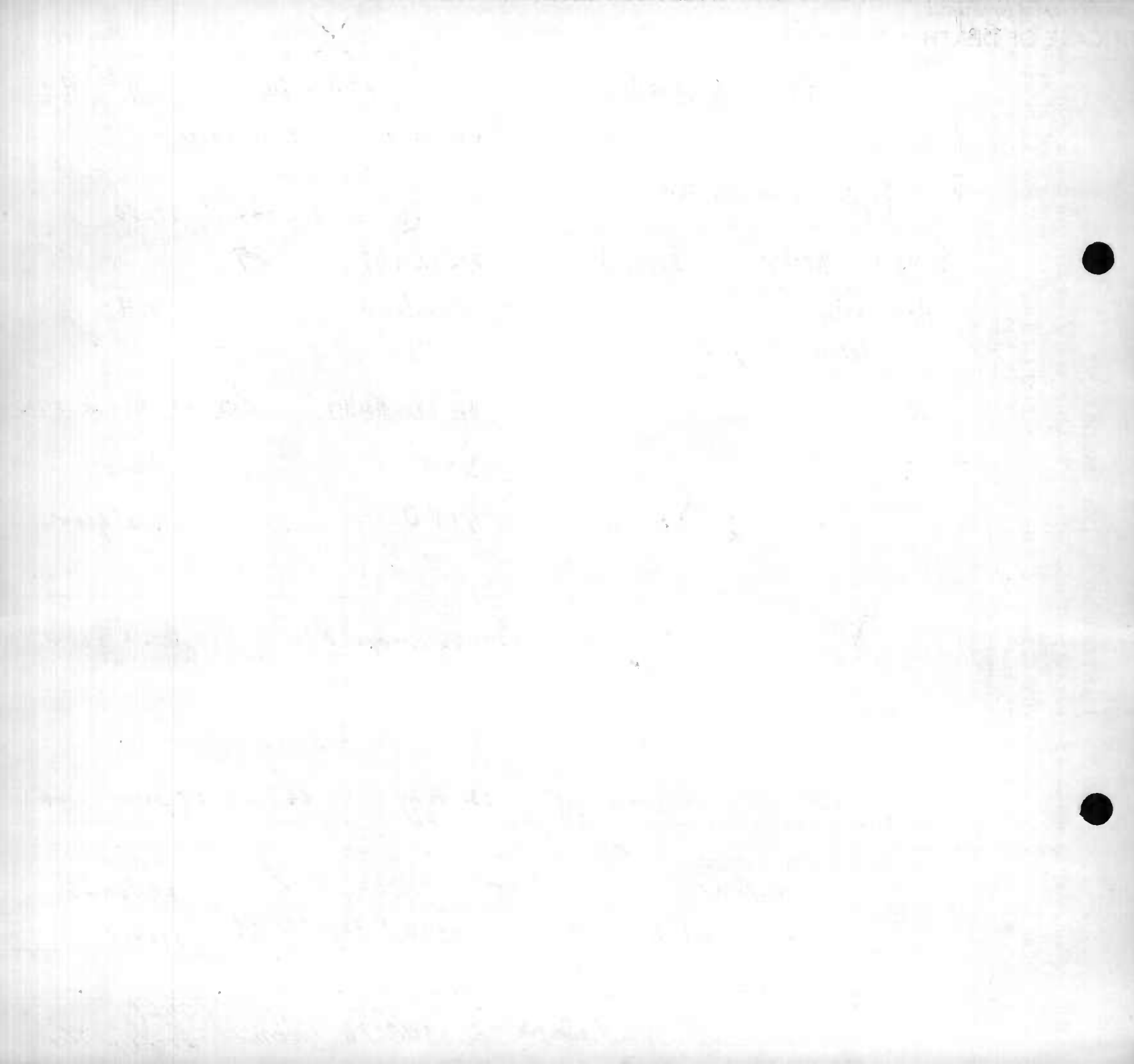
BIRTH NO. 66 06736		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06736	
M.E. CASE NO.		CERTIFICATE OF DEATH		1 9 P M.	
1. NAME OF DECEASED (Type or Print) Michael Petrochko		2. DATE AND HOUR OF DEATH July 1, 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rural - Rosedale 53-00 D. STREET ADDRESS (If rural, give location) 2228 Hamilton Ave			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 10, 1921	9. AGE (In years last birthday) 45	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Field Engineer		10B. KIND OF BUSINESS OR INDUSTRY Spray-Rent Corp		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael Petrochko		14. MOTHER'S MAIDEN NAME Mary Fedack	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 168-18-3135		17. INFORMANT Florence P. Petrochko	
18. 4-20-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Feb 1958 to July 1966, that (I) (we) lost sown the deceased olive on July 1, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert J. Lyden		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/2/66	
23C. PHYSICIAN'S NAME (Type) ROBERT J. LYDEN		23D. ADDRESS 6402 GOLDEN RIVER RD. M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/66		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Stanley	
25C. FUNERAL DIRECTOR Thelma Long		ADDRESS 1211 Chesaco Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

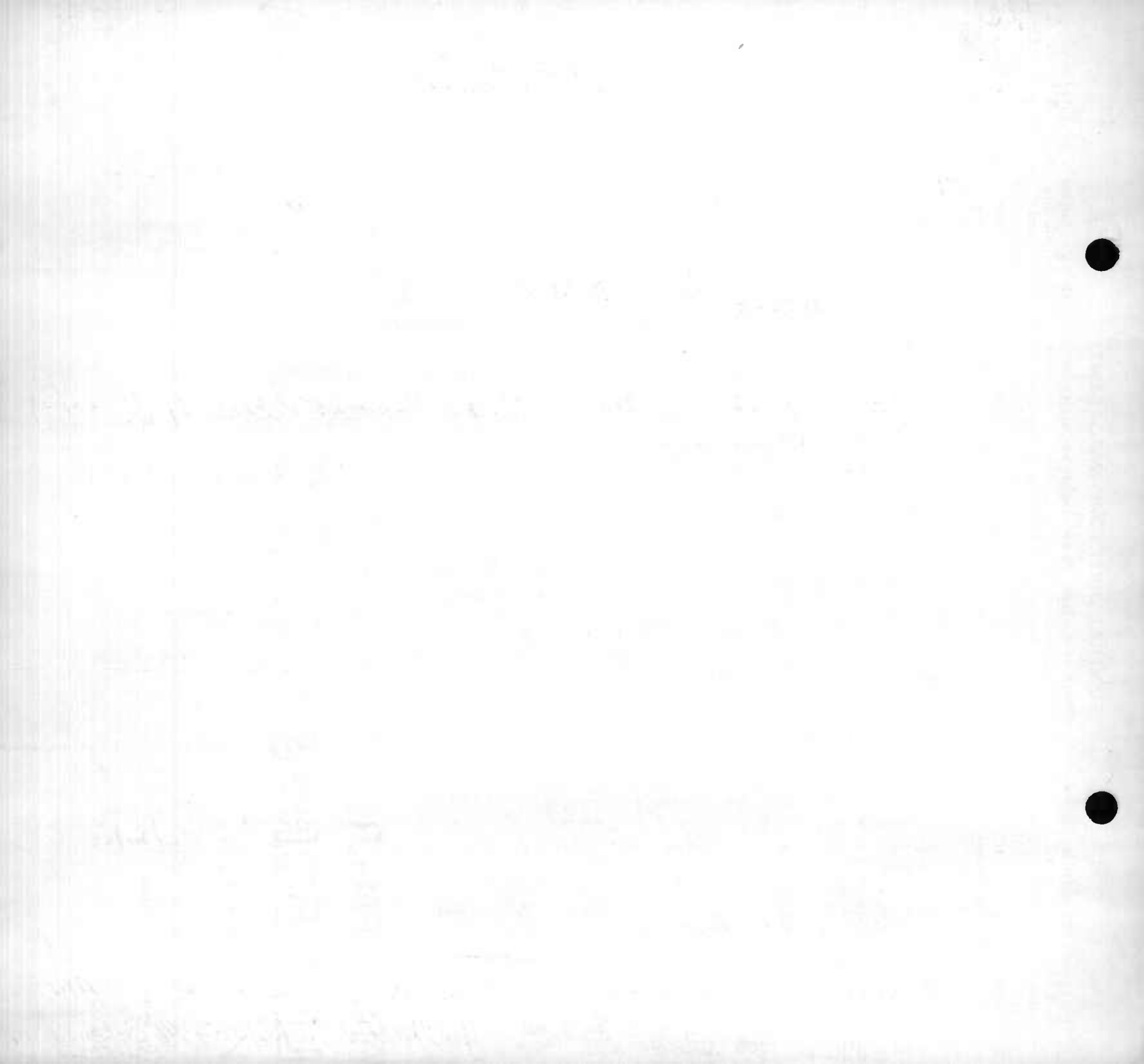
BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 66 06737					
BIRTH NO. 66 06737					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Anna M. Mueller					2. DATE AND HOUR OF DEATH 29 Jun 66 9:35 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			A. STATE Maryland		B. COUNTY Baltimore			
80 Fayette Convalescent Home					C. CITY OR TOWN Chase					
					D. STREET ADDRESS Pte 16 Box 366 191 21220					
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 22 Jan 1899		9. AGE (In years last birthday) 67		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Selfemployed Tavern		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Wenger					14. MOTHER'S MAIDEN NAME Perseantia					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Chas. Mueller			ADDRESS Box 366 Pte 16 21220		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO CrA					
ANTECEDENT CAUSES					(B) DUE TO NCD					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Interval BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?				
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (1) (this hospital) attended the deceased from 22 May 19 66 to 29 Jun 1966, that (1) (we) last saw the deceased alive on 29 Jun 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.										
23A. SIGNATURE J. Hulla					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 29 Jun 66			
23C. PHYSICIAN'S NAME (Type) J Hulla					23D. ADDRESS M.D. 2214 E Fayette St 21231					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-1966		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery			24D. LOCATION (City, town, or county) Baltimore Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Lassahn Fun'l Home		25D. ADDRESS 7401 Belair Rd				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06738		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06738	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William Farrelly, WILLIAM H. FARRELLY		2. DATE AND HOUR OF DEATH 6/30/66 5:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital		A. STATE Md.		B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.		11-03	
		D. STREET ADDRESS (If rural, give location) 211 W. Madison St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6/27/02	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Clerk, D. M. V.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael Farrelly		14. MOTHER'S MAIDEN NAME Margaret McCabe	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W. W. II		16. SOCIAL SECURITY NO. 218-22-6287		17. INFORMANT MISS MARGARET V. FARRELLY (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Intracerebral hemorrhage DUE TO (B) ASCVD, Diabetes Mellitus DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 9 days	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute MI, CHF, pneumonia					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/21 1966 to 6/30 1966, that (I) (we) last saw the deceased alive on 6/30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Lee Robbins		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/30/66	
23C. PHYSICIAN'S NAME (Type) E. LEE ROBBINS		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-2-66		24C. NAME OF CEMETERY MEADOWRIDGE MEM. PK	
24D. LOCATION (City, town, or county) Howard Co.		(State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR J. Walter Conklin	
25D. ADDRESS 5444 BELAIR RD.		BALTO 21206			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

GERRY W. BOLDEN

2. DATE AND HOUR PRONOUNCED DEAD

3 July 1966

10:13 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1717 S. Charles St.

5. SEX

Male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9-1-52

9. AGE (In years
last birthday)

13

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles S. Bolden

14. MOTHER'S MAIDEN NAME

Mildred Beech

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Charles S Bolden Same as line D

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Drowning
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

harbour

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Baltimore harbour-foot of Light St.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

July 3, 1966 8:23 a.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

drowned while attempting swimming

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/3/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/6/66

23C. NAME of CEMETERY or CREMATORY

Meadowridge Memorial Pk

23D. LOCATION

(City, town, or county)

Howard County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

VALLEY POLICE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 06740

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VERNON LOUIS BRODGEN

2. DATE AND HOUR PRONOUNCED DEAD

June 27, 1966

11:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1109 Barclay Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1629 Cliftview Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

12-21-35

9. AGE (In years
lost birthday)

30

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Tower Motor Ford

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Whitaker

14. MOTHER'S MAIDEN NAME

Mary Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Marie Jones 2235 Prentiss Pl.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Generalized Peritonitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Stab Wound of Abdomen Penetrating
Transverse Colon.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Biddle Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 26 '66 A.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed in left side of abdomen.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/27/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-1-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR 1735 Harford Ave ADDRESS

Marshall W. Jones, Jr.

10012

11-11-72

10012

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06741				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06741	
M.E. CASE NO.				1. NAME OF DECEASED (EVERETT) HARRY SMITH		2. DATE AND HOUR OF DEATH JULY 2, 1966 1:50 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
14 UNION MEMORIAL HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE #6 26-01	
				D. STREET ADDRESS (If rural, give location)		4308 WILLSHIRE AVE.	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/15/93	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Painting Contractor		11. BIRTHPLACE (State or foreign country) BROOKLYN, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK L. SMITH				14. MOTHER'S MAIDEN NAME BESSIE R. VAN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W W I		16. SOCIAL SECURITY NO. 110091177		17. INFORMANT ADDRESS MRS. MELBA R. SMITH SAME			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) CHRONIC PULMONARY EMPHYSEMA YEARS			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				GASTROINTESTINAL BLEEDING			
19A. DATE OF OPERATION 3/6/30/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PNEUMOTHORAX		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 6/30 1966 to 7/2 1966, that (1) (we) last saw the deceased alive on 7/1 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Frank Carozza				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/2/66	
23C. PHYSICIAN'S NAME (Type) DR. F. CAROZZA				23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/5/66		24C. NAME OF CEMETERY or CREMATORY LORRAINE PK. CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC.		ADDRESS BALTO. 14 MD.	

JUL 22 1961

ATLANTA

Handwritten signature or name, possibly "H. H. H."



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06742		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06742	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JAMES J. O'BIERNE		2. DATE AND HOUR OF DEATH June 30, 1966 11:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1223 Belvedere Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1223 E. Belvedere Ave.		5. SEX male	
6. RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH June 26, 1907	
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S., S.S. Bureau		11. BIRTHPLACE (State or foreign country) New Jersey York	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME O'Bierne		14. MOTHER'S MAIDEN NAME Mary Brady	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 21870-9000		17. INFORMANT Mrs. Margaret R. O'Bierne ADDRESS 1223 E. Belvedere	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Arteriosclerotic Heart Disease with Coronary Insufficiency.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH years.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis & Aneurysm		3 years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 1960 to 30 June 1966 , that (I) (we) last saw the deceased alive on 16 June 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Lauriston L. Keown				23B. DATE SIGNED 1 July 1966	
23C. PHYSICIAN'S NAME (Type) Dr. Lauriston L. Keown				23D. ADDRESS 431 E. Lake Ave., Baltimore	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7/4/66		24C. NAME OF CEMETERY OR CREMATORY Moreland M. Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Co		25A. DATE RECEIVED BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Farkner	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		25D. ADDRESS 5305 Harford Rd., 14			

Apprentice's Certificate
of the
General Assembly

Indorse & Seal

—
to the
X

1840

2000

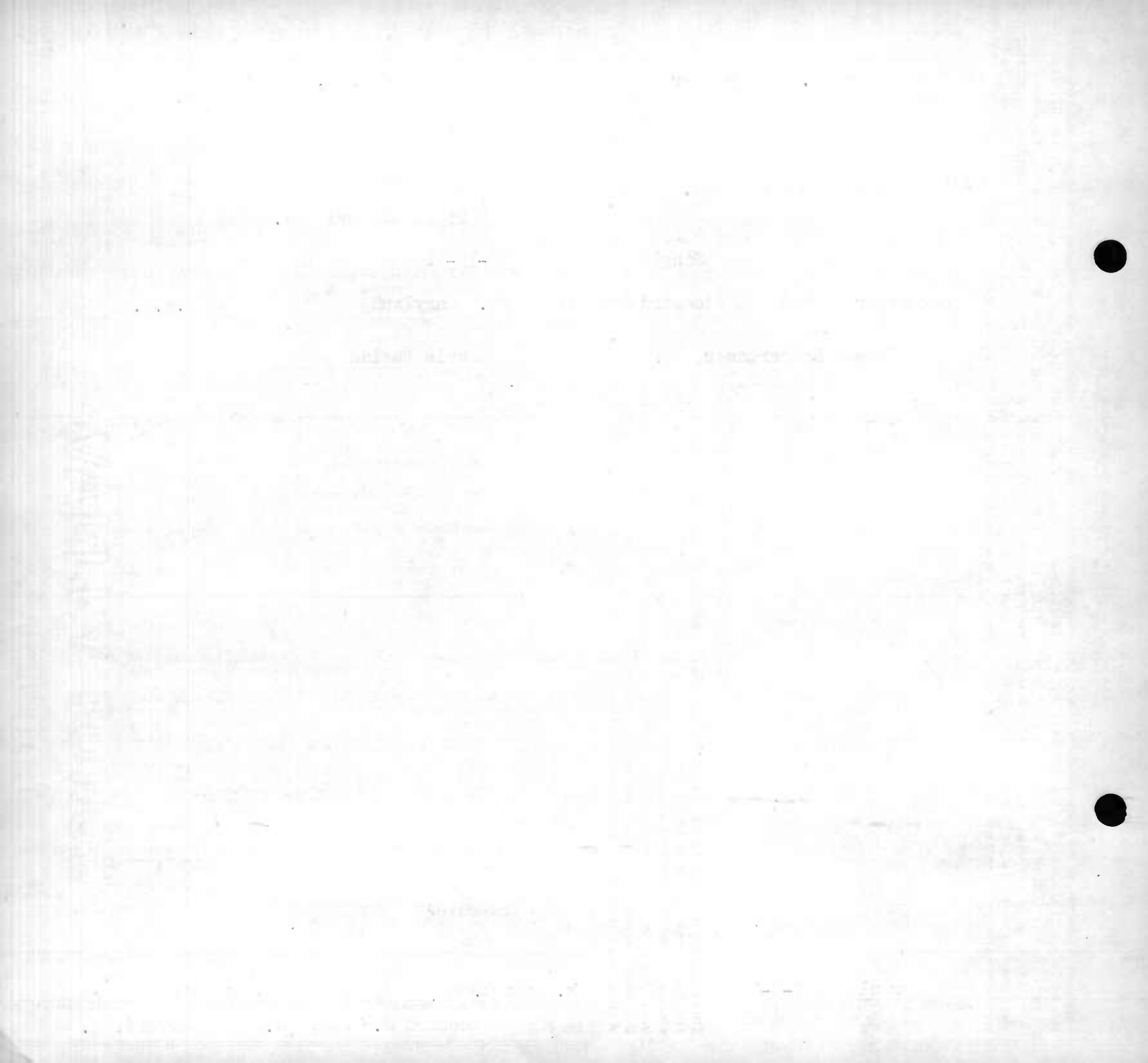
30 June

1840

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

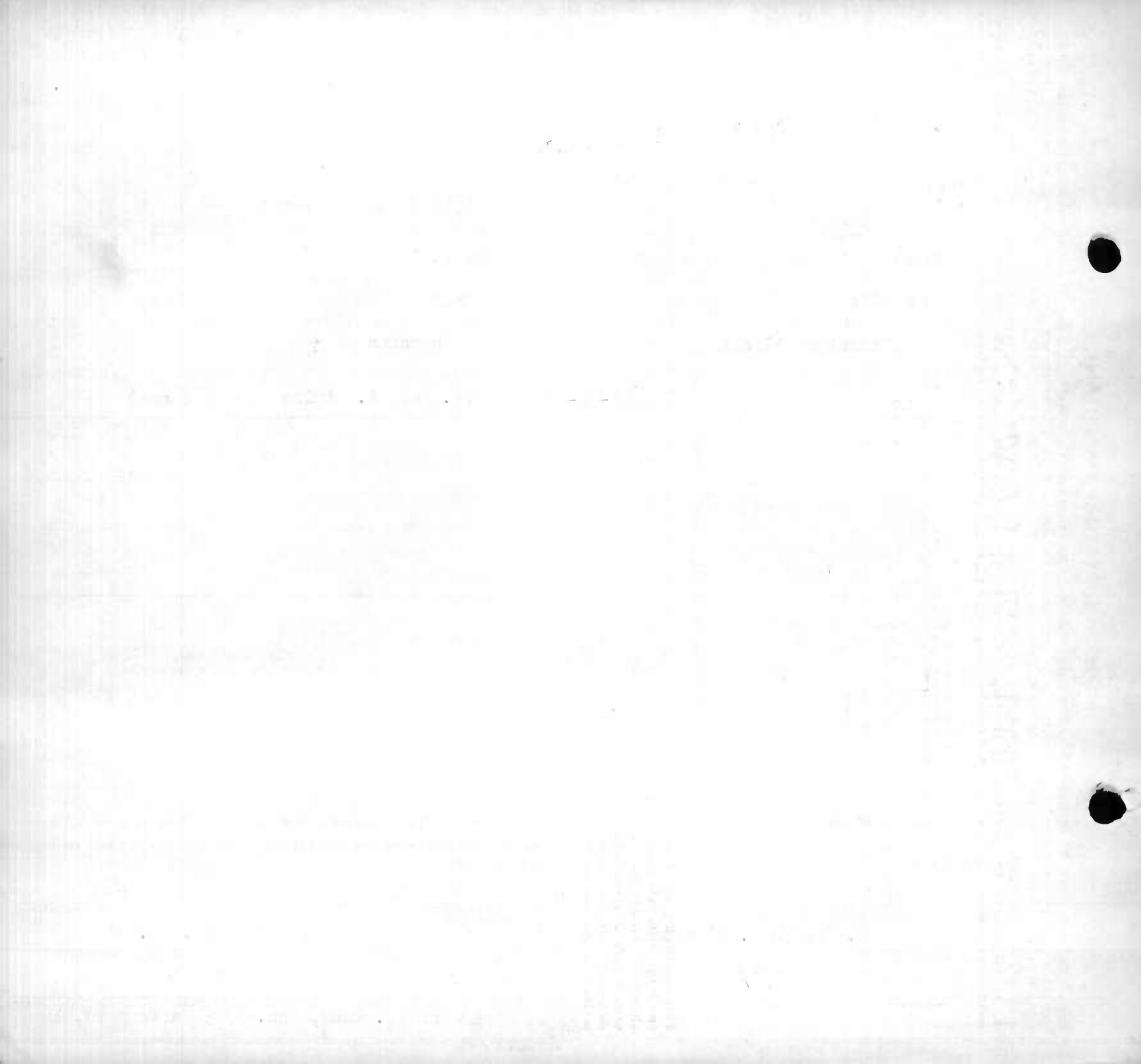
BIRTH NO. 66 06743				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06743	
1. NAME OF DECEASED (Type or Print) Alice M. Schearbauer				2. DATE AND HOUR OF DEATH July 1, 1966 M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2944 Guilford Ave.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 6-15-92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper (Ret)				10B. KIND OF BUSINESS OR INDUSTRY Stockard Shipping Corp. Maryland		11. BIRTHPLACE (State or foreign country)			
13. FATHER'S NAME Joseph Schearbauer				14. MOTHER'S MAIDEN NAME Marie Phelan					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-05-0665		17. INFORMANT ADDRESS Mrs Ruth Pfeiffer - 2944 Guilford Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I Acute Myocardial Infarction Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. CAUSE OF DEATH (A) DUE TO Extensive Myocardial Infarction Vascular Disease (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 2 yrs.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the hospital) attended the deceased from 3 Aug. 1964 to 24 June 1966 that (I) (we) last saw the deceased alive on 24 June 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.									
23A. SIGNATURE Wm. H. Kammer, Jr. M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 1 July 1966			
23C. PHYSICIAN'S NAME (Type) Wm. H. Kammer, Jr. M.D.				23D. ADDRESS 6011 York Rd. 21212					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-66		24C. NAME of CEMETERY or CREMATORY Lorraine Pk. Mausoleum		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966				25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06744				BALTIMORE CITY DEPARTMENT		Registered No. 66 06744	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				(Type or Print) MARY LIBERTO		July 2, 1966 3 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
4723 Shamrock Avenue				Maryland			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
housewife				Baltimore #6 26-02			
13. FATHER'S NAME				D. STREET ADDRESS (If rural, give location)			
Salvatore Alasha				4723 Shamrock Avenue			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
female		white		widowed		May 5, 1890	
9. AGE (In years lost birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
76		Italy		USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				215-01-5348		Mrs. Mary A. Cimino (Same)	
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				(A) <i>Myocardial infarction - Venous disease</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
II				(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 60 to 7/2 19 66, that (I) (we) last saw the deceased alive on 7/1 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED			
Joseph R. Liberto		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		7/2/66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Dr. Joseph R. Liberto		3508 Bank Street, Baltimore, Md.		burial		7/5/66	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Holy Redeemer Cemetery		Baltimore, Maryland		JUL 5 1966		Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. NAME OF REGISTRAR		25F. NAME OF REGISTRAR	
Leonard J. Ruck, Inc.		-5305 Harford rd, 14					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06745		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06745	
M.E. CASE NO.		1. NAME OF DECEASED James Robert Carnell		2. DATE AND HOUR OF DEATH July 1, 1966 3 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION Bolton Hill Nursing Care Center		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1327 Pentwood Rd. 27-09			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2/15/80 1890	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William James Carnell		14. MOTHER'S MAIDEN NAME Louise Tate	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Baltimore, Md. 21212 Mrs R Joseph Russell 1327 Pentwood Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) I 163X CAUSE OF DEATH (A) DUE TO Carcinoma of left lung INTERVAL BETWEEN ONSET AND DEATH 6 months		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. arteriosclerotic cardiovascular disease 10 years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (the hospital) attended the deceased from December 11, 1965 to July 1, 1966, that (I) last saw the deceased alive on July 1, 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Stanley Z. Felsenberg		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/1/66	
23C. PHYSICIAN'S NAME (Type) STANLEY Z. Felsenberg		23D. ADDRESS M.D. 1129 E. Baltimore St Baltimore 2, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/66		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION A.A. County, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Felsenberg	
25C. FUNERAL DIRECTOR The Cook-Brooks Inc.		ADDRESS Balt. Md.			

BC. for James R.Carnell born Feb.15,1890 in Virginia.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06746		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06746	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Grimm, William J.		
2. DATE AND HOUR OF DEATH 7/2/66 4 AM			M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland. B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hospital 2025 West Myrtle St. Baltimore 23 Md. 21223			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 2114 Edmondson Ave #23					
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1/26/1898	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph T. Grimm			14. MOTHER'S MAIDEN NAME Florence E. Mine		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Virginia E. Grimm Box 516 Rd#2 Serverna Park		
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Anterior Arteriosclerosis Generalized			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-2-66 19 to 7-2-66 19, that (I) (we) last saw the deceased alive on 7-2-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Antonio M. Estrada M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ANTONIO M. ESTRADA M.D.				23D. ADDRESS BON SECOURS HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/66		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21202					
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202	

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

MARY A. STEFKOVICH (Hiley-Wysocki)

2. DATE AND HOUR PRONOUNCED DEAD

June 30, 1966

11:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

CHURCH HOME & HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3133 Elliott Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 6, 1923

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machine Operator

10B. KIND OF BUSINESS OR INDUSTRY

Container Mfg. Co.

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Hiley

14. MOTHER'S MAIDEN NAME

Lillian Ratajczak

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216 16 4484

17. INFORMANT

John Stefkovich

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) 2nd and 3rd degree burns over
DUE TO majority of body surface

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Alley

21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?

3133 Elliott Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 10 66 10:44 A.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Set self on fire with gasoline

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-1-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/5/66

23C. NAME of CEMETERY or CREMATORY

St. Stanislaus Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 5 1966

24B. NAME OF REGISTRAR

Robert E. Jarboe, M.D.

24C. FUNERAL DIRECTOR

Bruzdzinski Funeral Home 1407 Eastern Ave.

ADDRESS

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

March 8, 1953

Machine Operator
Continental N. Co.
Boston, Mass.

Joseph Hiley
William H. Hiley

215 15 0000
John H. Hiley
Gene

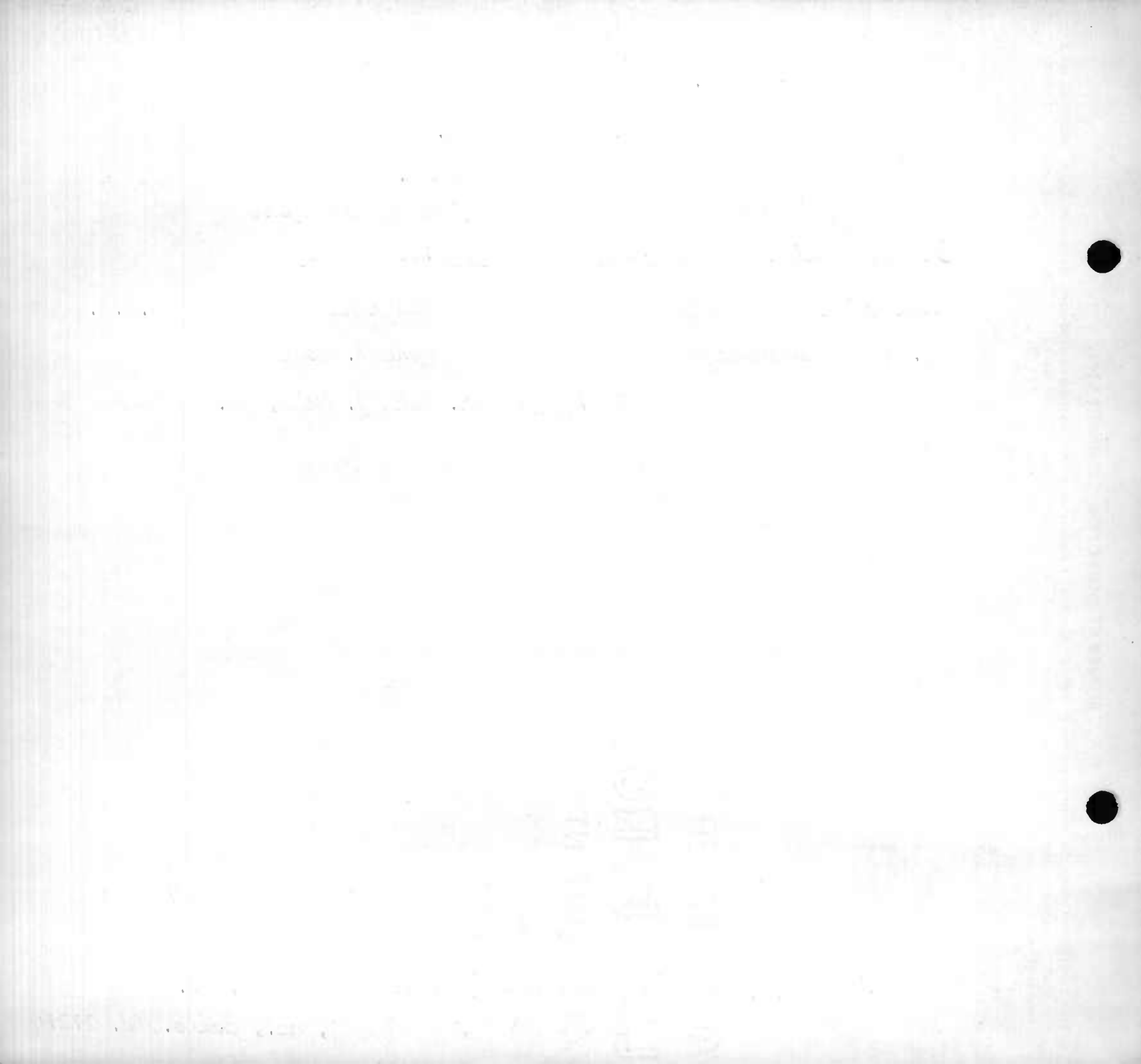
7/5/66
St. Elizabeth Cemetery
Belmont, Maryland

True and correct under oath

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

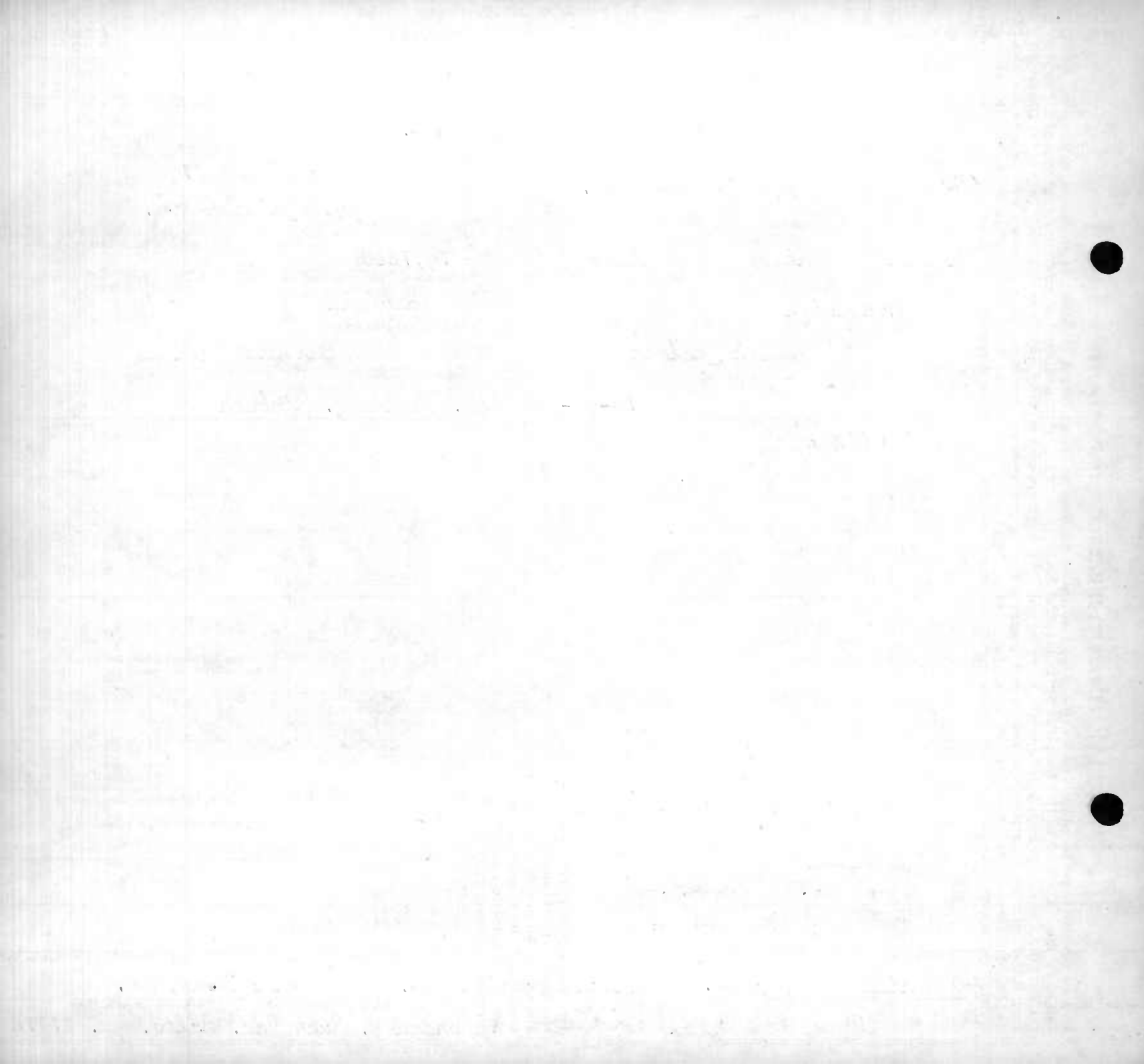
BIRTH NO. 66 06748		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06748	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MARY M. NAHM			2. DATE AND HOUR OF DEATH 7-5-66 12:55 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 9200 Chenoak Court		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5/5/1883	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME J. Henry Rosenberger		14. MOTHER'S MAIDEN NAME Cora M. Rose	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220143476		17. INFORMANT Mr. John J. Nahm, Jr.	
ADDRESS Same					
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Arteriosclerotic Cardiovascular disease (B) DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH Many					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-17-66 19 66 to 7-5 19 66 , that (I) (we) last saw the deceased alive on 7-5 19 66 and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William T. Mason M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 7-5-66	
23C. PHYSICIAN'S NAME (Type) William T. MASON M.D.				23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/66		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR S. J. Ruff, Inc., Balto., Md. 21214	
ADDRESS 21214					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 06749					CERTIFICATE OF DEATH		Registered No. 66 06749		
1. NAME OF DECEASED (Type or Print) <i>Magdalena S. Pahren</i>					2. DATE AND HOUR OF DEATH <i>July 3, 1966 8¹⁵ A. M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>5402 Grindon Ave.</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____				
5. SEX <i>Female</i>					6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>		8. DATE OF BIRTH <i>May 14, 1880</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Joseph Edelman</i>					14. MOTHER'S MAIDEN NAME <i>Barbara Zellers</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>216-46-5866</i>		17. INFORMANT <i>Mrs. Thelma E. Rimbach</i>		ADDRESS <i>(Same)</i>
18. <i>199.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Abdominal cancer</i>					CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Broncho-pneumonia</i>					(B) DUE TO		(C) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<i>Broncho-pneumonia</i>		<i>3 days</i>		
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1966</i> to <i>July 3, 1966</i> , that (I) was lost saw the deceased alive on <i>July 2, 1966</i> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.									
23A. SIGNATURE <i>R Donald Jandorf</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7-3-66</i>		
23C. PHYSICIAN'S NAME (Type) <i>R Donald Jandorf</i>					23D. ADDRESS M.D. <i>6077 Hartford Rd</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/7/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Moreland Memorial Cem.</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1966</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>			



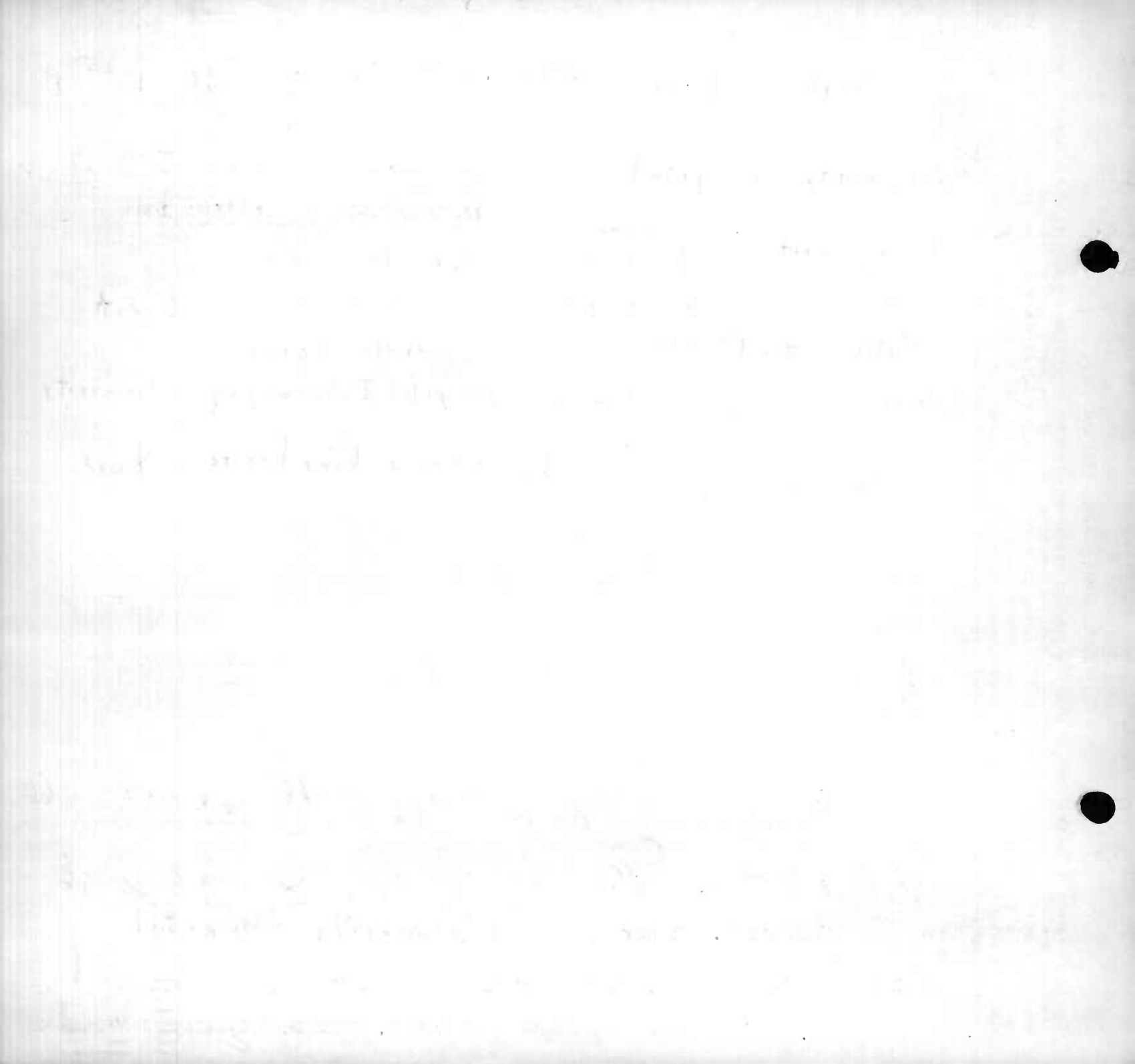
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 06750</u>	
BIRTH NO. <u>66 06750</u>		CERTIFICATE OF DEATH	
M.E. CASE NO.		WILLIAM G. YAGER	
1. NAME OF DECEASED (Type or Print) <u>Yager, William</u>		2. DATE AND HOUR OF DEATH <u>7-1-66</u> <u>5:30 p.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>BON Secours Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Anne Arundel</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BON Secours Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Linthicum</u> <u>52-00</u>	
		D. STREET ADDRESS (If rural, give location) <u>904 Lynvue Rd.</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>9/11/1907</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXXXXXXXXXXXXXXXX</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CASEMAKER</u>	9. AGE (In years last birthday) <u>65</u>
13. FATHER'S NAME <u>Yager, William</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>Peters, Emma</u>		17. INFORMANT <u>MRS. CATHERINE A. YAGER, SAME AS 4D</u>	
16. SOCIAL SECURITY NO. <u>212-01-5314</u>		ADDRESS <u>Admission Sheet</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Prostatic carcinoma</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized metastasis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1966</u> to <u>7/1, 1966</u> and that (I) (we) last saw the deceased alive on <u>July 1, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Amable A. Mendonza</u>		23B. DATE SIGNED <u>7-1-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>AMABLE A. MENDONZA</u>		23D. ADDRESS <u>Bon Secours Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-5-66</u>	
24C. NAME OF CEMETERY or CREMATORY <u>LOUDON PARK CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>	
25C. FUNERAL DIRECTOR <u>HOWARD H. HUBBARD</u>		ADDRESS <u>4107 WILKENS AVENUE 21229</u>	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



66 06752

BALTIMORE CITY HEALTH DEPARTMENT

66 06752

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MICHAEL A. RAMAGNANO

2. DATE AND HOUR PRONOUNCED DEAD

July 4, 1966 7:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Church Home Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore -- Dundalk

D. STREET ADDRESS (If rural, give location)

7532 Rabon Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 13- 1912

9. AGE (in years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Checker

10B. KIND OF BUSINESS OR INDUSTRY

American Can Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Anthony Ramagnano

14. MOTHER'S MAIDEN NAME

Sophie Bruno

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

212-09-5217

17. INFORMANT

ADDRESS

Wife, Mrs. Helen Ramagnano, # 4, a, b, c, d.

18.

420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

Arteriosclerotic Heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

July 4, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 7-1966

23C. NAME of CEMETERY or CREMATORY

St. Stanislaus

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland 21224

24A. DATE REC'D BY HEALTH DEPT.

JUL 5 1966

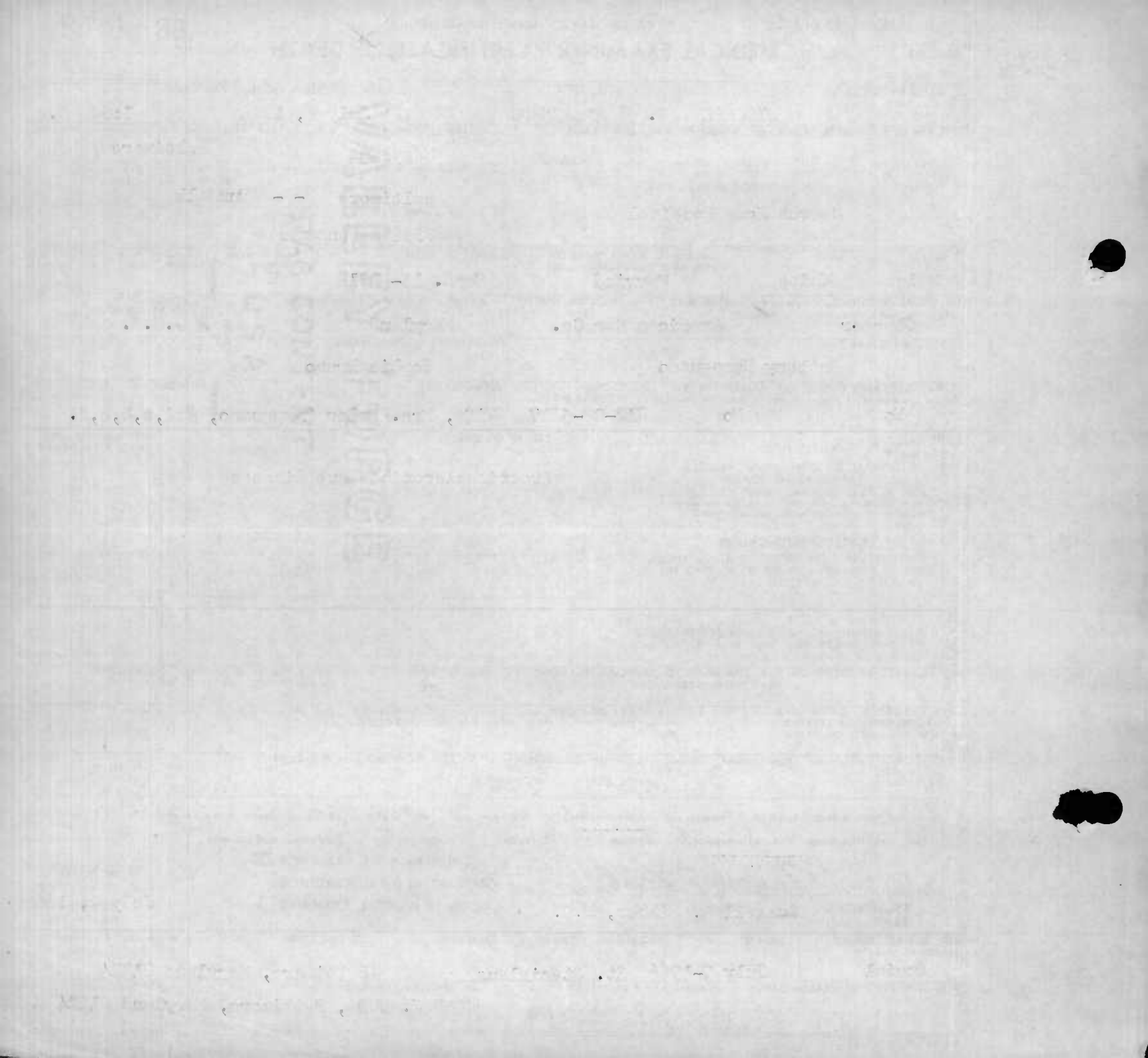
24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

JOHN J. DUDA, Baltimore, Maryland 21224

ADDRESS



For approval by medical examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06753		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06753	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Y. McLeod		2. DATE AND HOUR OF DEATH July 1, 1966 2:30 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 703 S. 49th Street 21224			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 19, 1901	9. AGE (In years last birthday) 64	10. CITIZEN OF WHAT COUNTRY? U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Wright		10B. KIND OF BUSINESS OR INDUSTRY Fisher Body		11. BIRTHPLACE (State or foreign country) Scotland	
13. FATHER'S NAME Hugh McLeod			14. MOTHER'S MAIDEN NAME Margaret Young		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 230-012-070		17. INFORMANT Mrs. Jessie McLeod	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) CORONARY OCCLUSION DUE TO (B) CORONARY ARTERY DUE TO (C) DISEASE		INTERVAL BETWEEN ONSET AND DEATH SUDDEN DEATH 1 YR 6 MO.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? III in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT 20 1958 to JULY 1 1966, that (I) (we) lost saw the deceased alive on JUNE 20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Miceli		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED JULY 2, 1966	
23C. PHYSICIAN'S NAME (Type) Joseph Miceli		23D. ADDRESS M.D. 108 S. Taylor Ave. Essex, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 5-66		24C. NAME of CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Trumps Mill Rd. Balto. MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR John J. Duda		25D. ADDRESS 7922 Wise Ave. Dundalk, Md.			

X

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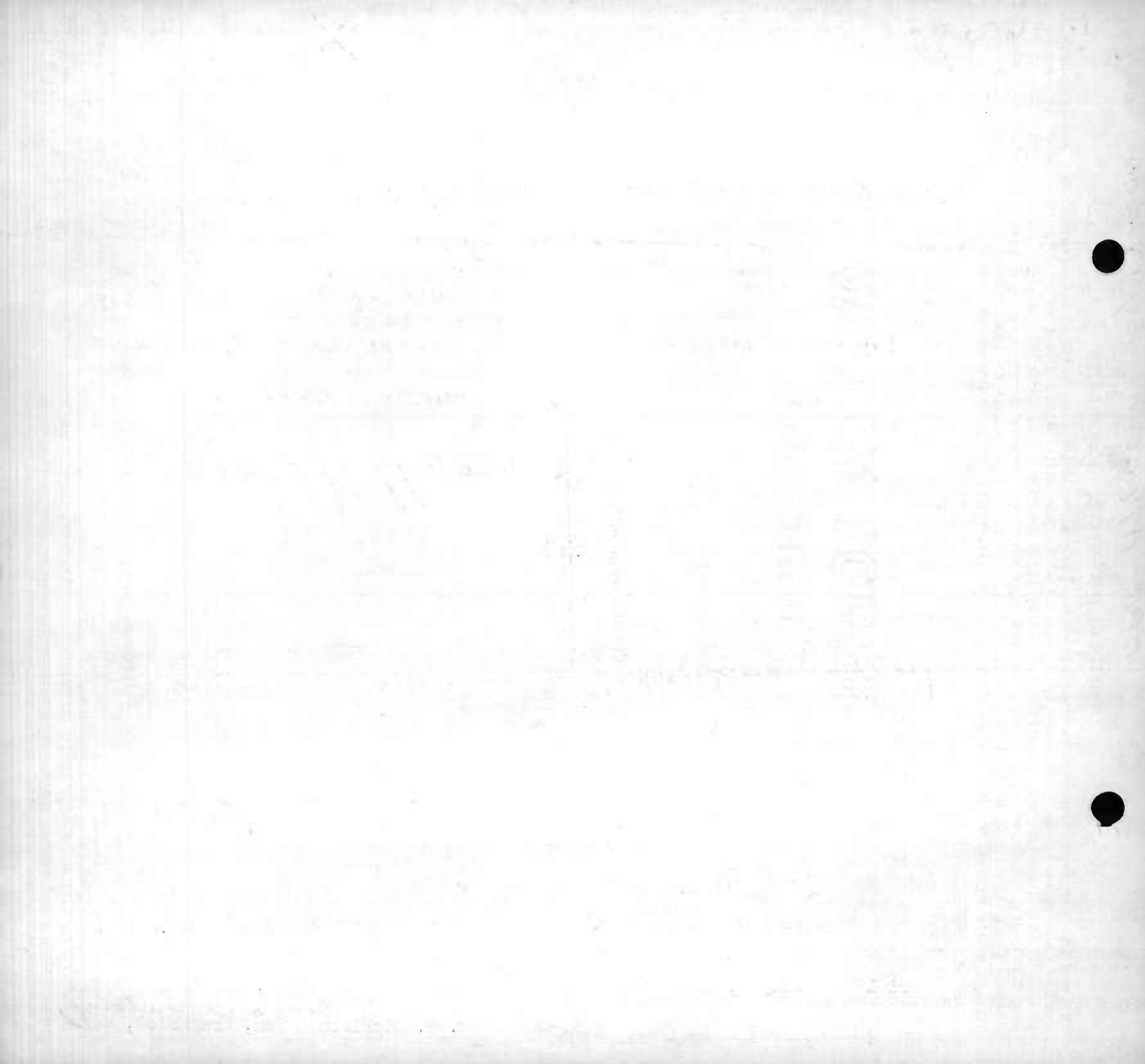


FOR APPROVAL BY MEDICAL EXAM.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06754		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06754	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MICHAEL RENEE MYERS		2. DATE AND HOUR OF DEATH June 30, 1966 3:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) FREDERICK 60-11	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL-BALTIMORE		D. STREET ADDRESS (If rural, give location) 104 W. 9th ST.			
5. SEX M	6. RACE W	7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (specify) BABY	8. DATE OF BIRTH 2/24/66	9. AGE (In years last birthday) 4	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME SHERMAN MYERS			14. MOTHER'S MAIDEN NAME CATHERINE ZIMMERMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HOSPITAL RECORD -	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Tetralogy of Fallot		CAUSE OF DEATH Tetralogy of Fallot		INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 6/29/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TETRALOGY		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/22 1966 to 6/30/ 1966, that (I) (we) lost saw the deceased alive on 6/30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Attar M.D.		23B. DATE SIGNED 6/30/1966			
23C. PHYSICIAN'S NAME (Type) SAFUM ATTAR		23D. ADDRESS UNIVERSITY HOSP. BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 2, 1966		24C. NAME OF CEMETERY or CREMATORY Mount Olivet Cemetery	
24D. LOCATION Frederick, Maryland		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1966		25B. NAME OF REGISTRAR R. E. Farber		25C. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06735				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06755	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>McKenzie, Ervel J.</i>				2. DATE AND HOUR OF DEATH <i>7/3/66 10:30 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE <i>Maryland</i>			
				B. COUNTY <i>Baltimore</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>124 W. Ostend St.</i>			
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>8 31 1907</i>	
						9. AGE (In years last birthday) <i>58</i>	
						If Under 1 Yr. Months Days	
						If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe Fitter</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Beth. Steel</i>		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>							
13. FATHER'S NAME <i>George Mc Kenzie</i>				14. MOTHER'S MAIDEN NAME <i>Beetha Polly</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>	
						ADDRESS <i>Same</i>	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>425.1 I</i>				CAUSE OF DEATH <i>Acute Myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH	
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>7/3</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7/3</i> 19 <i>66</i> to <i>7/3</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>7/3</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Carroll C. Balantyne</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7 6 1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Cedar Hill</i>		24D. LOCATION (City, town, or county) (State) <i>Brooklyn, A. A. Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>McCully inf. 130 E. State</i>		ADDRESS <i>30</i>	

March 2, 1904

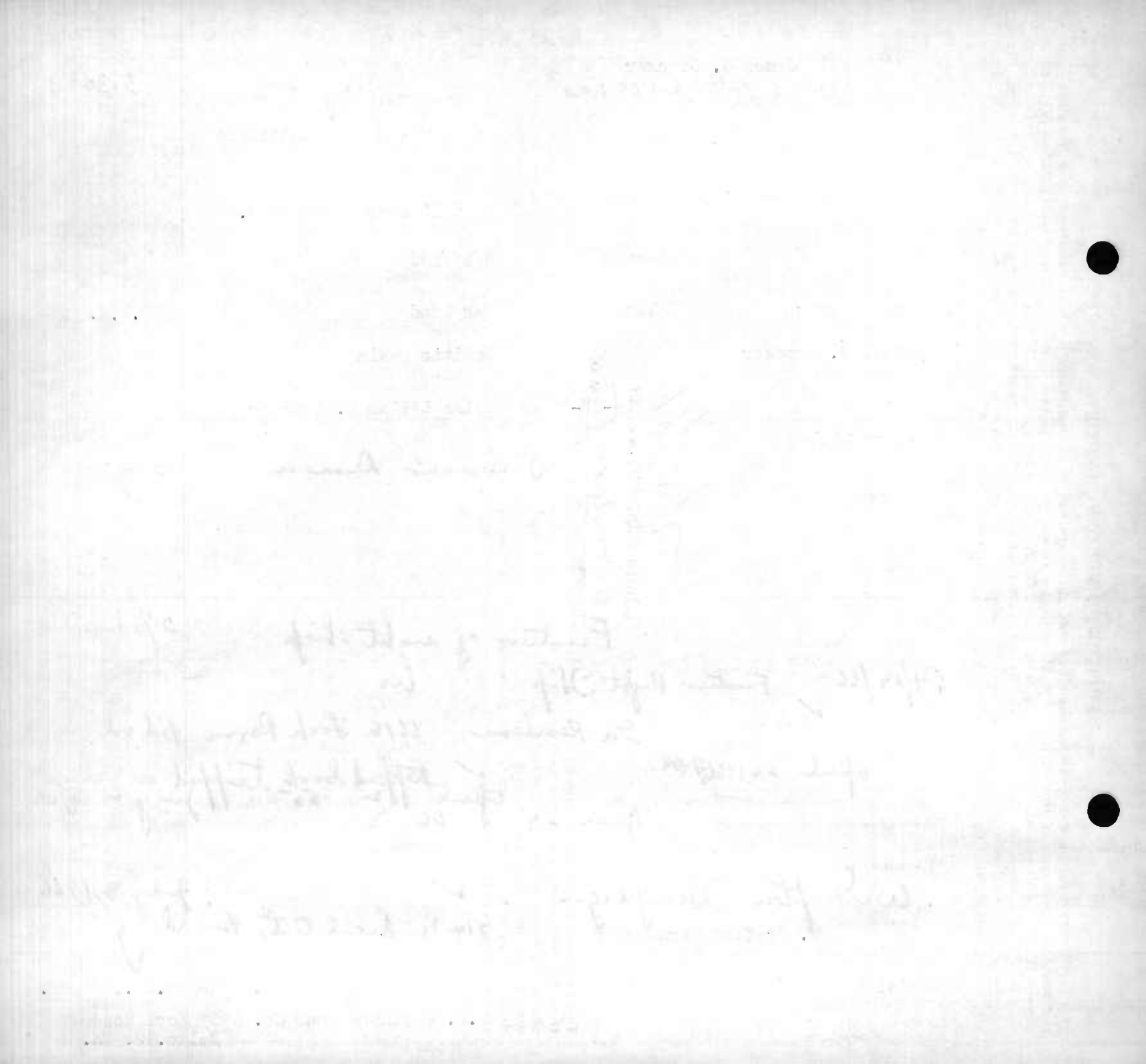
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March 2, 1904

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 06756					CERTIFICATE OF DEATH					Registered No. 66 06756				
1. NAME OF DECEASED James G. Crocker (Type or Print)										2. DATE AND HOUR OF DEATH July 2, 1966 5:30 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Long Green Nursing Home										4. USUAL RESIDENCE (When deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson D. STREET ADDRESS (If rural, give location) 6616 Loch Raven Blvd.				
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 6/15/1885		9. AGE (In years last birthday) 81		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman					10B. KIND OF BUSINESS OR INDUSTRY Sales					11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel G. Crocker										14. MOTHER'S MAIDEN NAME Letitia Davis				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 15-07-9592A					17. INFORMANT Miss Eilian E. Crocker (Same)				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture of right hip										CAUSE OF DEATH (A) Parvovirus Disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 years		
19A. DATE OF OPERATION 4/24/66					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture Right Hip					20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) In Residence					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 6616 Loch Raven Blvd.				
21D. TIME OF INJURY (APPROX.) April 23, 1966 7 AM					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					21F. HOW DID INJURY OCCUR? Slipped back, tripped on rug				
22. I certify that (I) (this hospital) attended the deceased from April 22, 1966 to July 2, 1966, that (I) (we) lost saw the deceased alive on June 29, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										23A. SIGNATURE W. Grafton Hersperger M.D.			23B. DATE SIGNED July 3, 1966	
23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger					23D. ADDRESS 214 Medical Art Building									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 7/6/1966		24C. NAME of CEMETERY or CREMATORY Druid Ridge			24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.				
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966					25B. NAME OF REGISTRAR Robert E. Farley, M.D.					25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.				



FUNERAL DIRECTOR: IMPORTANT

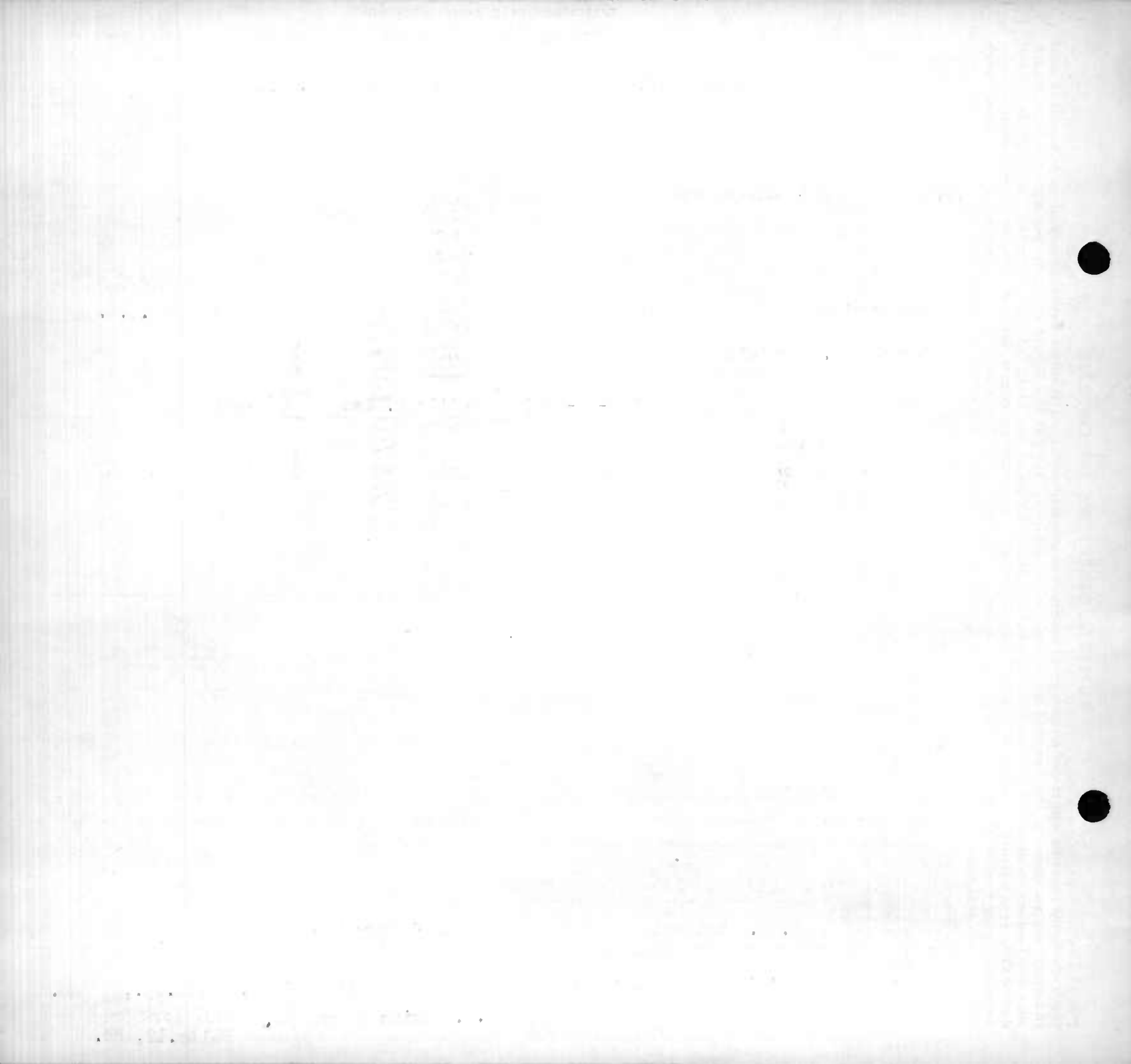
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06757		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06757	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) CHARLES D. GRACE			2. DATE AND HOUR OF DEATH July 2, 1966 4:00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Lutherville-Timonium 21093 D. STREET ADDRESS (If rural, give location) 511 Surrey Road		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED MARRIED	8. DATE OF BIRTH 7-29-1905	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10B. KIND OF BUSINESS OR INDUSTRY Engineering		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Harry Eugene Grace			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 213-28-5833		17. INFORMANT Mildred R. Grace
			ADDRESS Same		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular Disease			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 hours 6 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 19 60 to July 2, 19 1966 , that (I) (we) last saw the deceased alive on June 25, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE Robert T. Parker				23B. DATE SIGNED 7/2/1966	
23C. PHYSICIAN'S NAME (Type) ROBERT T. PARKER				23D. ADDRESS South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-5-66		24C. NAME OF CEMETERY or CREMATORY Parkwood	
24D. LOCATION Parkville		24E. ADDRESS Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd., Balto.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

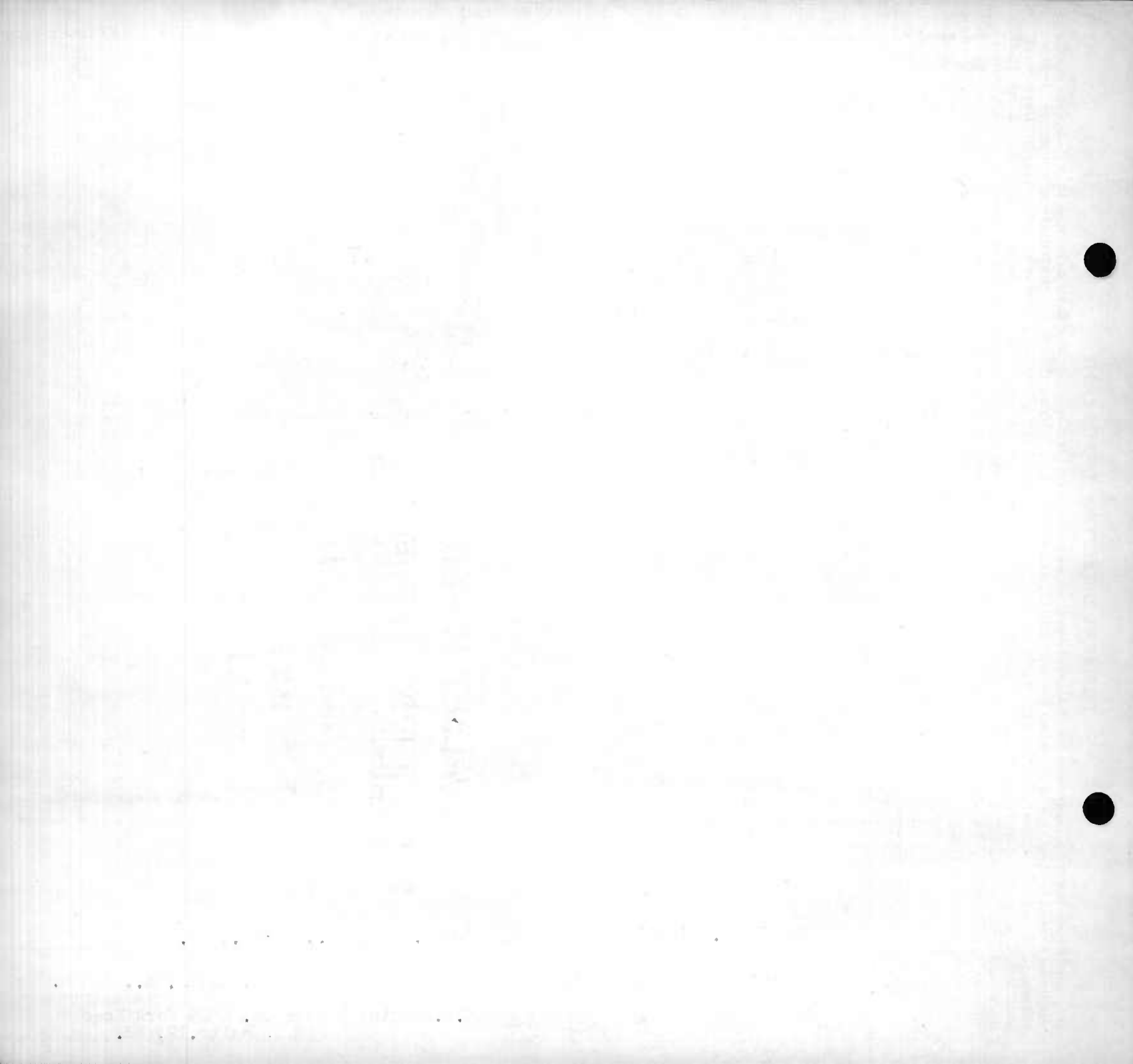
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 06758</u>	
BIRTH NO. <u>66 06758</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Helen Warfield Lang</u>		2. DATE AND HOUR OF DEATH <u>July 2, 1966</u> <u>4:30 P. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>505 Hollen Road</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-4/8</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>505 Hollen Road</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>3/27/1892</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Underwriter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles D. Warfield</u>				14. MOTHER'S MAIDEN NAME <u>Ella Cox</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-1373</u>		17. INFORMANT ADDRESS <u>Philip H. Lang (Same)</u>			
18. <u>345 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>MULTIPLE SCLEROSIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>NON</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u>	
19A. DATE OF OPERATION <u>0 NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ONE</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> 19 <u>66</u> to <u>July 2</u> 19 <u>66</u> , that (I) last last saw the deceased alive on <u>July 1</u> 19 <u>66</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.							
23A. SIGNATURE <u>A. S. Chalfant</u> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>July 5, 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. S. Chalfant</u>				23D. ADDRESS <u>6201 York Road</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/5/1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1966</u>		25B. NAME OF REGISTRAR <u>P. J. E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H. W. Jenkins & Sons Co. 4905 York Road Balto., Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

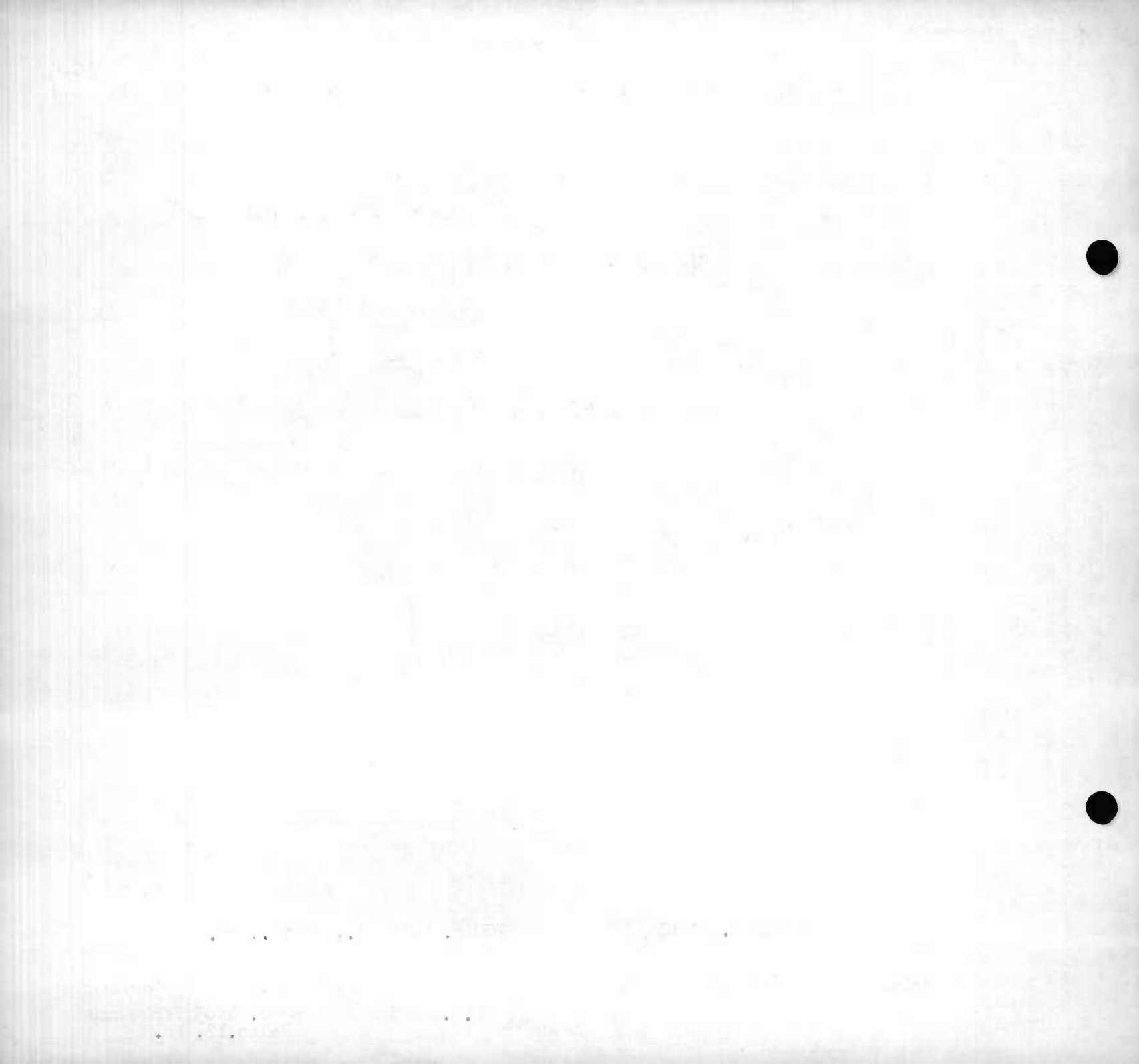
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06759</u>	
BIRTH NO. <u>66 06759</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type in Print) <u>Hooper, Mrs. Mathilde Bevan</u>		2. DATE AND HOUR OF DEATH <u>July 3 - 1966</u> <u>5 a.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>13-07</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Keswick Home</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>701 W. 40th St.</u>	
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>9/4/1883</u>	9. AGE (In years lost birthday) <u>82 y/5</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore - Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Dr. Charles F. Bevan</u>		14. MOTHER'S MAIDEN NAME <u>Tillie Heald</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-9035</u>		17. INFORMANT <u>Rachel C. Gibson - R.D.</u>	
18. <u>450.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Generalized Arteriosclerosis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		ADDRESS <u>Keswick Records</u>	
19. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>September 19 62</u> to <u>July 3 1966</u> , that (I) (we) last saw the deceased alive on <u>July 3 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Harold P. Biehl</u>	
23B. DATE SIGNED <u>4 July 66</u>		23C. PHYSICIAN'S NAME (Type) <u>Harold P. Biehl</u>		23D. ADDRESS M.D. <u>700 W. 40th St., Balto., Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/5/1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>	
25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		25D. ADDRESS <u>4905 York Road Balto., Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06760		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06760	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Kaestner, Miss Gertrude</i>		2. DATE AND HOUR OF DEATH <i>7-3-66</i> <i>10⁴⁰ P</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>9-03</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>91 Keswick, 700 W. 40th. St.</i>		D. STREET ADDRESS (If rural, give location) <i>614 E. 33rd. St.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>July 20, 1885</i>	9. AGE (In years last birthday) <i>80</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Ernest August Kaestner</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Schmidt</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-46-9566</i>		17. INFORMANT <i>Helen Keller R.H. 700 W. 40th. St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>356.11</i>		CAUSE OF DEATH (A) <i>Amphotrophic lateral sclerosis</i> (B) <i>—</i> (C) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 yrs</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April 21, 1966</i> to <i>July 3, 1966</i> , that (I) (we) last saw the deceased alive on <i>July 3, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>Harold P. Biehl</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7/4/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Harold P. Biehl</i>		23D. ADDRESS M.D. <i>700 W. 40th St., Balto., Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/6/1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.</i>			



66 06761

BALTIMORE CITY HEALTH DEPARTMENT

66 06761

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

STEPHEN E. DINKEL

2. DATE AND HOUR PRONOUNCED DEAD

June 1, 1966

10:00 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

1634 Aliceanne Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1634 Aliceanne Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widower

8. DATE OF BIRTH

9. AGE (In years
last birthday)
39If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles A.

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

W-W-1 1

16. SOCIAL
SECURITY NO.
309-20-3690

17. INFORMANT

ADDRESS
4054 Ogletown Rd.
Charles A. Dinkel Newark, Del.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Overdose of barbiturates
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Acute alcoholism

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1634 Aliceanne Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
? 1966 ? m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK☒

21F. HOW DID INJURY OCCUR?

Ingested overdose of barbiturates

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Judiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-1-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/8/66

23C. NAME of CEMETERY or CREMATORY

National

23D. LOCATION

(City, town, or county)

(State)

Baltimore.Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 6 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Paul E. Chenowith 3617 Chestnut Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06762</u>	
BIRTH NO. <u>66 06762</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>66 06762</u>		1. NAME OF DECEASED (Type or Print) <u>James J. MARSHALL</u>		2. DATE AND HOUR OF DEATH <u>6-27-66</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>206 S. Clinton St.</u> (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>26-10</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO.</u> D. STREET ADDRESS (If rural, give location) <u>206 S. Clinton St.</u>			
5. SEX <u>M.</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>8-13-88</u>	9. AGE (In years lost birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE FITTER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Standard oil</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-4509</u>		17. INFORMANT <u>EMANUEL JENSEN</u> ADDRESS <u>8303 NUNELL</u> <u>RD. #34</u>	
18. <u>43X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Chronic Coronary Arteriosclerosis 17 years</u> (B) DUE TO <u>Hypertensive Cardio-Vascular Disease 20 years</u> (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Chronic Cholecystitis</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/12/66</u> 19 <u>51</u> to <u>6/27</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/23</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Melvin F. Pohlek</u>				23B. DATE SIGNED <u>6/28/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>MELVIN F. POHEK</u>				23D. ADDRESS M.D. <u>3603 BELAIR RD. BALTO. MD.</u>	
24A. BURIAL REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/30/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bohemian Nat'l</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH/DEPT.			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Helma A. Hoffmann</u>		ADDRESS <u>Hoffmann Funeral Home</u>	

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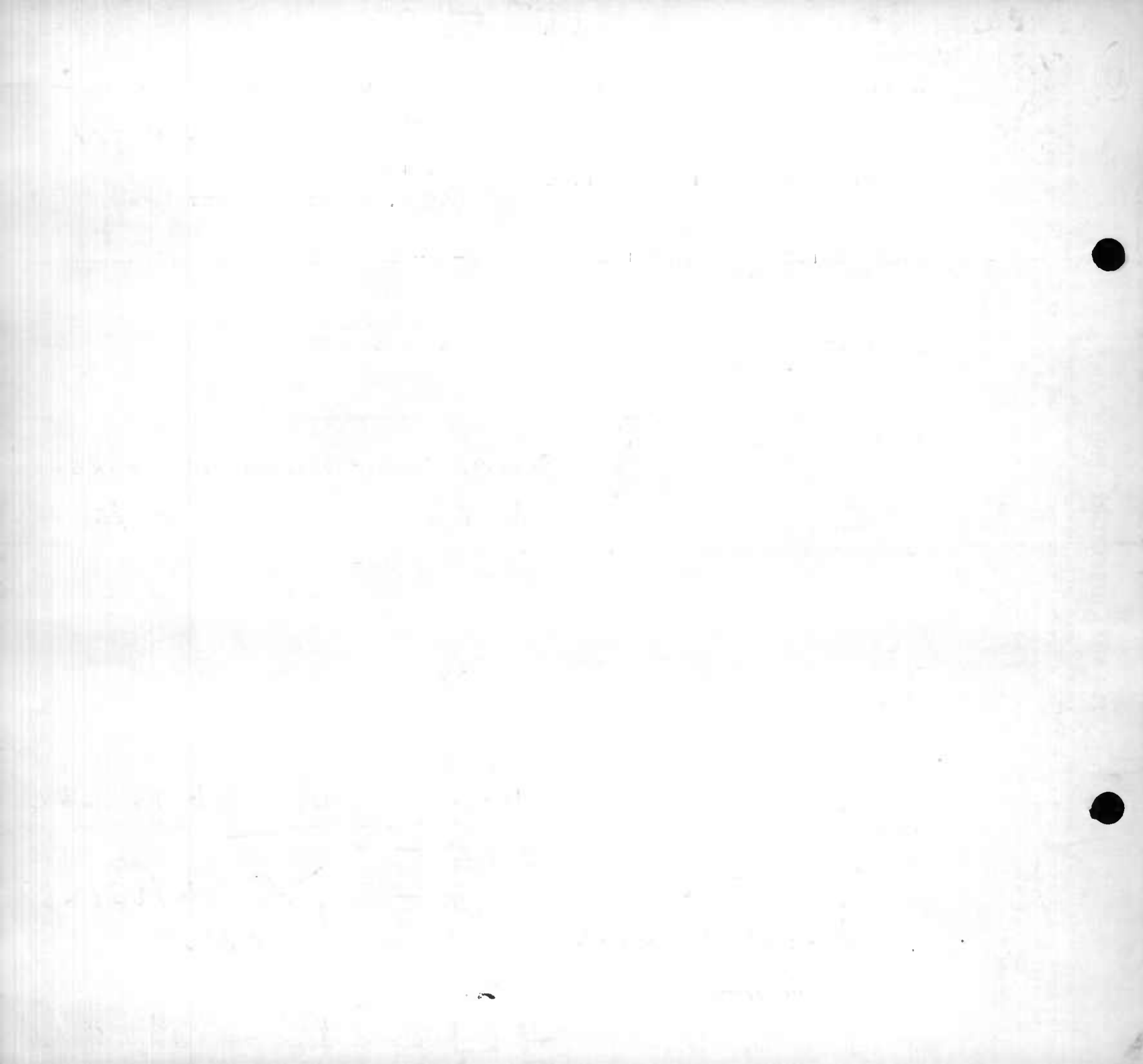
2017 202

WALSH & CO. LTD.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

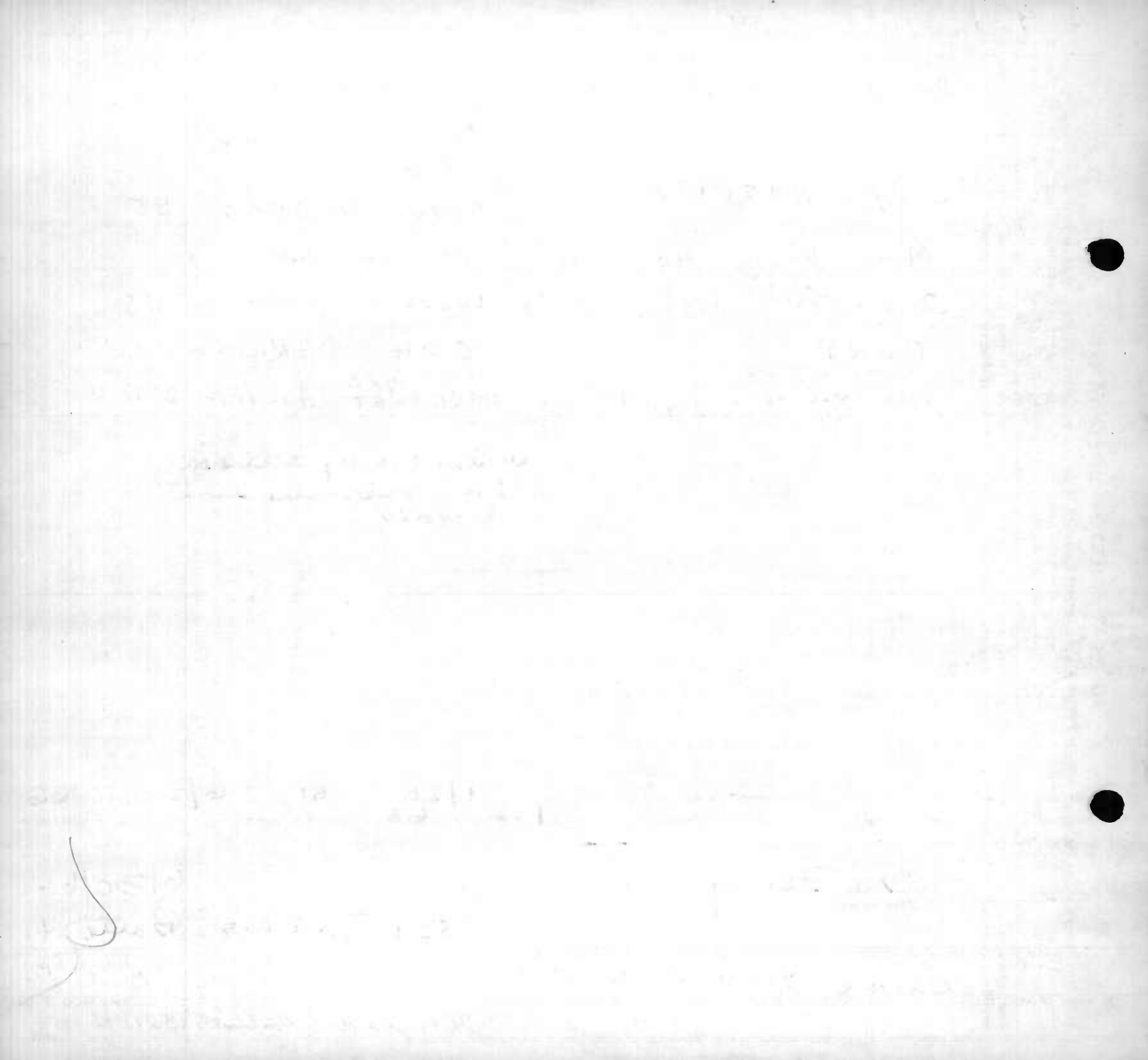
BIRTH NO. 66 06763		CERTIFICATE OF DEATH		Registered No. 66 06763	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) WILLIAM PETTY			2. DATE AND HOUR OF DEATH 6-25-66 8:30 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNSHOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-11 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 913 S. CHESLER STREET CLINTON		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-12-12	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME LAWRENCE			14. MOTHER'S MAIDEN NAME CLARA SOAPER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) SEVERE CONGESTIVE FAILURE DUE TO ASCVD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH SEVERE CONGESTIVE FAILURE DUE TO ASCVD		INTERVAL BETWEEN ONSET AND DEATH 6 YRS.
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-22-66 to 6-25-66 that (I) (we) last saw the deceased alive on 6/25 19 66 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert T. Haase M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff <input checked="" type="checkbox"/>			23B. DATE SIGNED 6/25/66		
23C. PHYSICIAN'S NAME (Type) ASHLEY T. HAASE M.D.			23D. ADDRESS JOHNS HOPKINS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/66		24C. NAME of CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Robert E. Farber, M.A.		25C. FUNERAL DIRECTOR Thelma A. Hoffmann		ADDRESS 3218 Hudson St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06784	
BIRTH NO. 66 06784		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DELBERT C. AILIFF		2. DATE AND HOUR OF DEATH 6-28-66	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 26-11.			
17. FATHER'S NAME BERT		14. MOTHER'S MAIDEN NAME 'ORA DARLINGTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 8-6-41 7-9-45		16. SOCIAL SECURITY NO. 232-286-197		17. INFORMANT MRS. MARGARET AILIFF	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) acute coronary occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arterio sclerotic heart disease.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 1/20 1961 to 6/28 1966 . that (I) last saw the deceased alive on 3/22 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the hospital) (did not) view the body after death.					
23A. SIGNATURE Thelma D. Hoffman Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/30/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 3501 Fair Ave - Balto 24.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-66		24C. NAME of CEMETERY or CREMATORY Balto. National	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR Thelma D. Hoffman		25D. ADDRESS 3218 Hudson St.			



CERTIFICATE OF DEATH

Registered No.

66 06765

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Sorrell, Anna S.

2. DATE AND HOUR OF DEATH

7/1/66

6:05 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore 21223 007

D. STREET ADDRESS (If rural, give location)

1808 Lauretta Avenue

5. SEX

FEMALE

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

11/25/79

9. AGE (In years
last birthday)

86

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Lee

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 EASTERN AVENUE #21224

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Cerebral vascular accident

30 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

Generalized Arteriosclerotic
cardiovascular disease

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

metastatic squamous cell carcinoma of leg.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At
Work ☐Not While
At Work ☐22. I certify that ~~the~~ (this hospital) attended the deceased from 6/20 19 66 to 7/1 19 66.
that ~~the~~ (we) last saw the deceased alive on 7/1 19 66 and that in ~~my~~ (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Carl W. Winterstein

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/1/66

23C. PHYSICIAN'S
NAME (Type)

Carl W. Winterstein

M.D.

23D. ADDRESS
4940 Eastern Avenue #21224
Baltimore City Hospitals24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE RECEIVED BY HEALTH DEPARTMENT

25B. NAME OF REGISTRAR

Robert E. Farley

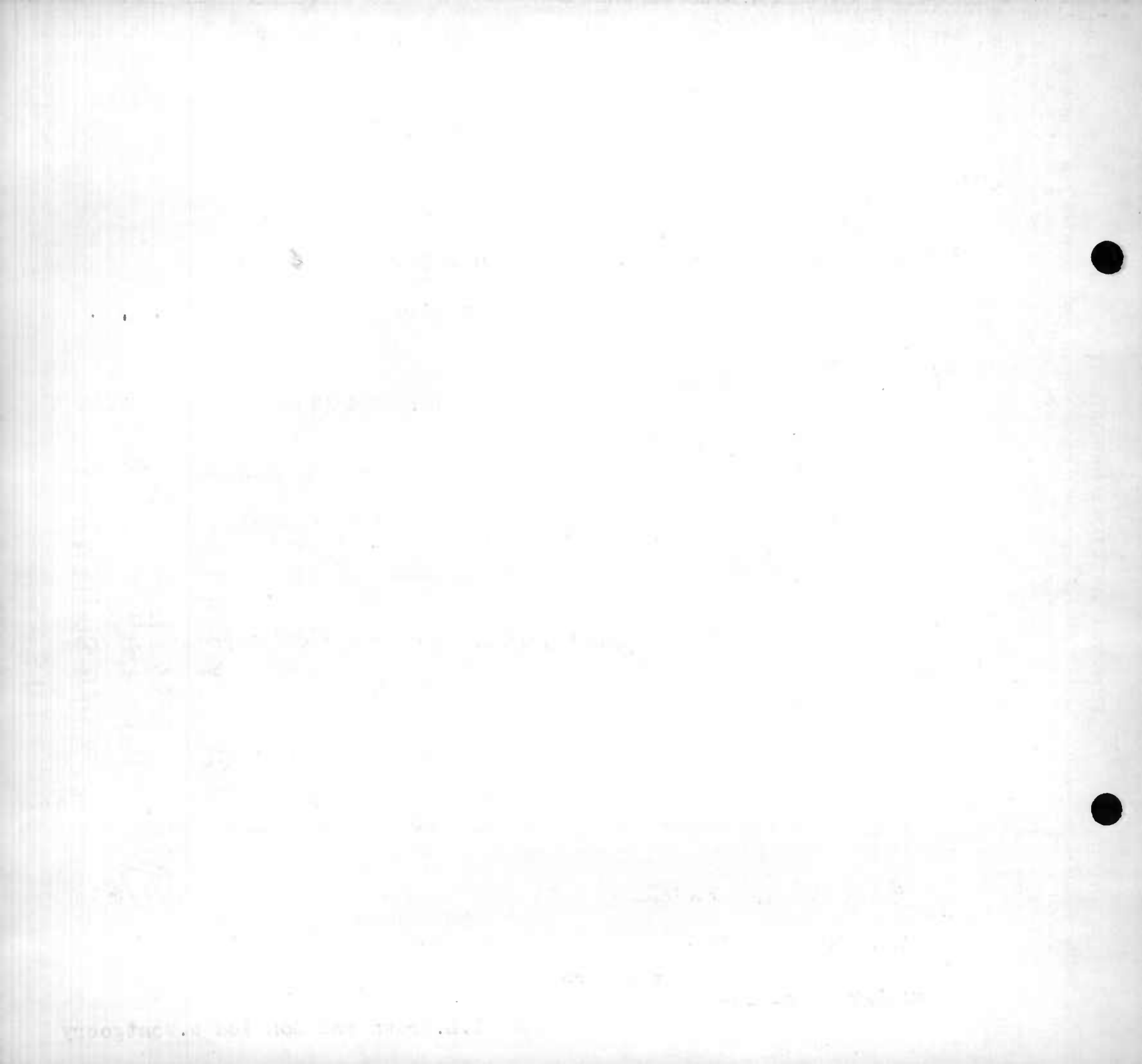
25C. FUNERAL DIRECTOR

ADDRESS

I.L. Brown and Son 108 W. Montgoery

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



46-88-91
NW F 65-12

66 06766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

66 06766

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Hildred Franklin

2. DATE AND HOUR OF DEATH

7/1/66

8:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 Eastern Avenue
Baltimore Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND ANNE ARUNDEL COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

GLEN BURNIE

D. STREET ADDRESS (If rural, give location)

RFD RT 320

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

4/27/13

9. AGE (In years
last birthday)

53

If Under 1 Yr.

Months

Days

Hours

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

JOSEPH

14. MOTHER'S MAIDEN NAME

SARAH

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH, 4940 Eastern Ave, Balto. Md. 21224

18. 134.317-204.3
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A)
DUE TO

Moniliasis

(B)
DUE TO

Acute myeloblastic leukemia 4 months

(C)

INTERVAL BETWEEN
ONSET AND DEATH

3 days

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from 6-5 19 66 to 7/1 19 66.
that (I) ~~was~~ lost saw the deceased alive on 7/1 19 66 and that in (my) ~~own~~ opinion death occurred on the date
and hour and from the causes stated above. (I) ~~was~~ (did) ~~not~~ view the body after death.

23A. SIGNATURE

Laurice McAfee

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/1/66

23C. PHYSICIAN'S
NAME (Type)

LAURICE MCAFEE

M.D.

23D. ADDRESS Baltimore City Hospitals

4940 Eastern Ave, Balto., Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

7-7-66

24C. NAME of CEMETERY or CREMATORY

Hall's Mem Church Yard

24D. LOCATION

A.A.CO., MD.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 6 1966 R. L. E. Farley

I. L. Brown and Son, 108 W. Montgomery

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06767		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06767	
M.E. CASE NO. Donohoe, Grace Agnes (Sister Elizabeth)		CERTIFICATE OF DEATH		July 5, 1966 12:30 am	
1. NAME OF DECEASED (Type or Print) DONOHOE, Grace Agnes (Sister Elizabeth)		2. DATE AND HOUR OF DEATH July 5, 1966 12:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Villa St. Michael 4000 Forest Hill Road Baltimore 7, Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 28-41			
D. STREET ADDRESS (If rural, give location) 4000 Forest Hill Road					
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Feb. 2, 1879	9. AGE (In years last birthday) 87 86	10. If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious Sister		10B. KIND OF BUSINESS OR INDUSTRY Child Care Worker		11. BIRTHPLACE (State or foreign country) Boston - Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Chas. A. Donohoe		14. MOTHER'S MAIDEN NAME Delia Quirk			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-54-0053		17. INFORMANT Sister Mary Louise, Adm.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cardio Vascular Collapse DUE TO General Arterial Sclerosis (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 week 14 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 19 52 to July 5, 19 66, that (I) (we) last saw the deceased alive on June 28, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. P. Alagia, M. D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 5, 1966	
23C. PHYSICIAN'S NAME (Type) D. P. Alagia, M. D.		23D. ADDRESS 326 E. ...			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/66		24C. NAME OF CEMETERY or CREMATORY St. Joseph's	
24D. LOCATION Emmitsburg, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Stewart & Mowen Co. 108 W. North Av., City	

TO : [illegible]
FROM : [illegible]

DATE : [illegible]
SUBJECT : [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

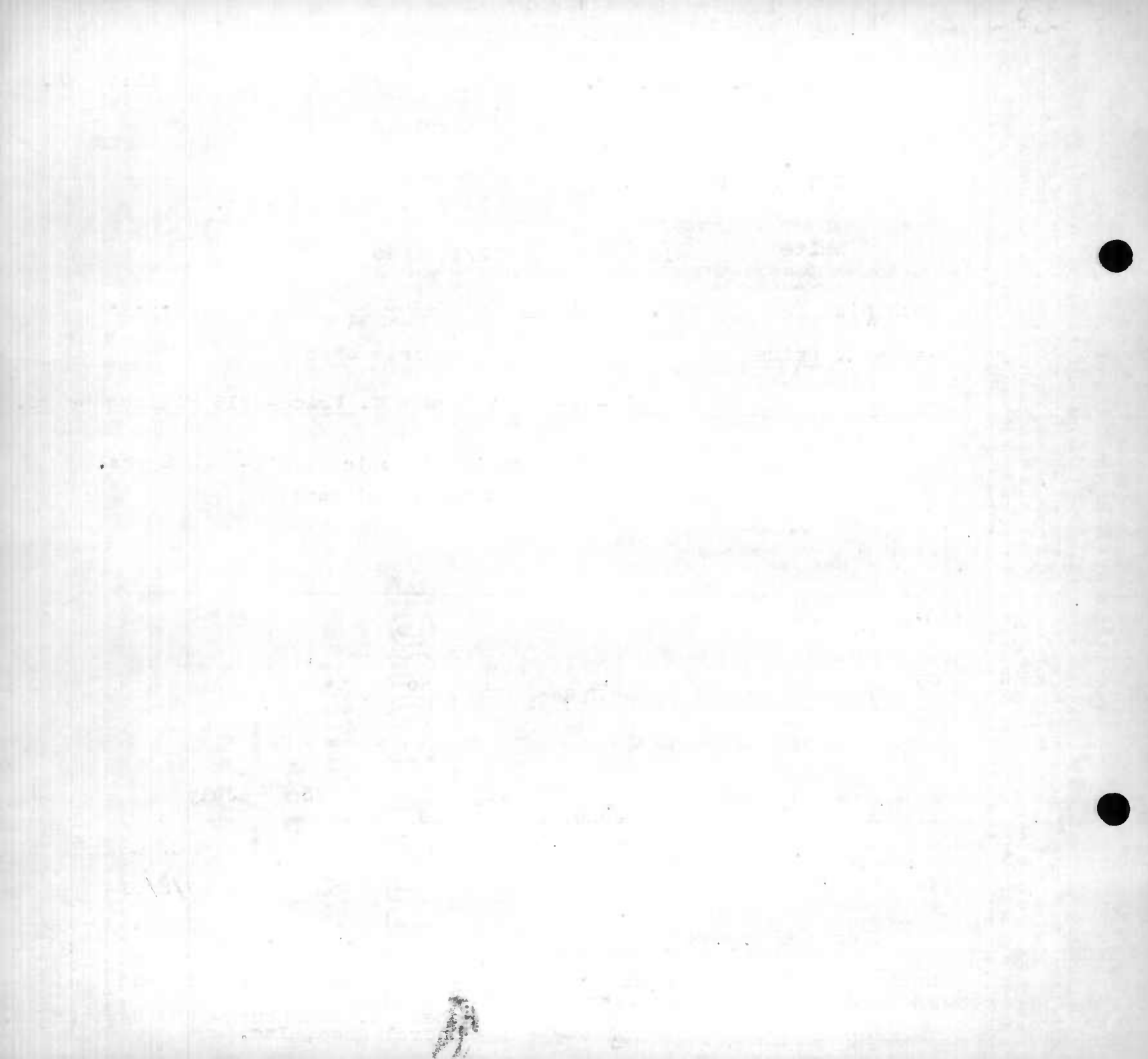
13. [illegible]

14. [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06768	
BIRTH NO. 66 06768		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William S. Price, Sr.		7/3/66 11:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) E. 2235 Jefferson St.		Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2235 E. Jefferson St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12/31/1876	9. AGE (In years lost birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James H. Price		14. MOTHER'S MAIDEN NAME Virginia Shae		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-3536A		17. INFORMANT ADDRESS James T. Price-3316 Willoughby Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Arteriosclerotic Cardio-vascular Disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>65</u> to <u>July</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>June 29</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Clarence W. LeDoux</i> M.D.				23B. DATE SIGNED 7/5/66	
23C. PHYSICIAN'S NAME (Type) Clarence LeDoux				23D. ADDRESS M.D. 3023 Eastern Ave. BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/66		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR Robert C. Altenburg-6009 Harford Rd.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert C. Altenburg-6009 Harford Rd.		25C. FUNERAL DIRECTOR ADDRESS Funeral Home, Inc.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06769</u>	
BIRTH NO. <u>66 06769</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>OLA MARIE Anderson</u>		2. DATE AND HOUR OF DEATH <u>6-29-66</u> <u>12:30 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Harford</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hosp.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Aberdeen</u>			
		D. STREET ADDRESS (If rural, give location) <u>1 Victory St.</u>			
5. SEX <u>F.</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>6-3-63</u>	9. AGE (In years last birthday) <u>3</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Click</u>		14. MOTHER'S MAIDEN NAME <u>Edith Hall</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT ADDRESS <u>Mrs. Ola Mae Anderson, 1 Victory St. Aberdeen Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ruptured Appendicitis - Peritonitis</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from <u>6-29</u> 19 <u>66</u> to <u>6-29</u> 19 <u>66</u> , that (we) last saw the deceased alive on <u>6-29</u> 19 <u>66</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. Behrooz</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-29-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. Behrooz, M.D.</u>		23D. ADDRESS <u>South Baltimore General Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-2-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cokesbury Memorial Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Abingdon Harford Md</u>					
25A. DATE RECEIVED BY HEALTH DEPT. <u>JUL 6 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard K. McComas & Son, Abingdon, Md.</u>	

Perforated
- 1000

M. B. King

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06770		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06770	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) BERTNA J. WHITEFORD				2. DATE AND HOUR OF DEATH JULY 3, 1966 13:20 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE (Ferndale) D. STREET ADDRESS (If rural, give location) 606 BROADVIEW BLVD.			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/22/98	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN ROSS				14. MOTHER'S MAIDEN NAME EDITH LOGAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-01-9070		17. INFORMANT Mr. Charles A. Whiteford		ADDRESS ADMISSION HISTORY (HUSBAND) Same As #2	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				19. CAUSE OF DEATH (A) DUE TO Pneumonia (B) DUE TO Cerebrovascular accident (C) Maliquancy of colon		INTERVAL BETWEEN ONSET AND DEATH 3 days denon - when	
19A. DATE OF OPERATION 6/9/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LARGE CARCINOMA IN LOWER		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from June 9 1966 to July 3 1966 , that (I) last saw the deceased alive on July 3 1966 and that in (my) and opinion death occurred on the date and hour and from the causes stated above. (I) did view the body after death.							
23A. SIGNATURE Jerry Bain Rogers				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 3, 1966	
23C. PHYSICIAN'S NAME (Type) JERRY BAIN ROGERS		23D. ADDRESS CHURCH HOME AND HOSPITAL					
24A. BURIAL CREATION, REMOVAL (Specify) Burial		24B. DATE July 7/66		24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Park		24D. LOCATION (City, town or county) (State) Glen Burnie, Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Farley, MA		25C. FUNERAL DIRECTOR R. V. Singleton			

22

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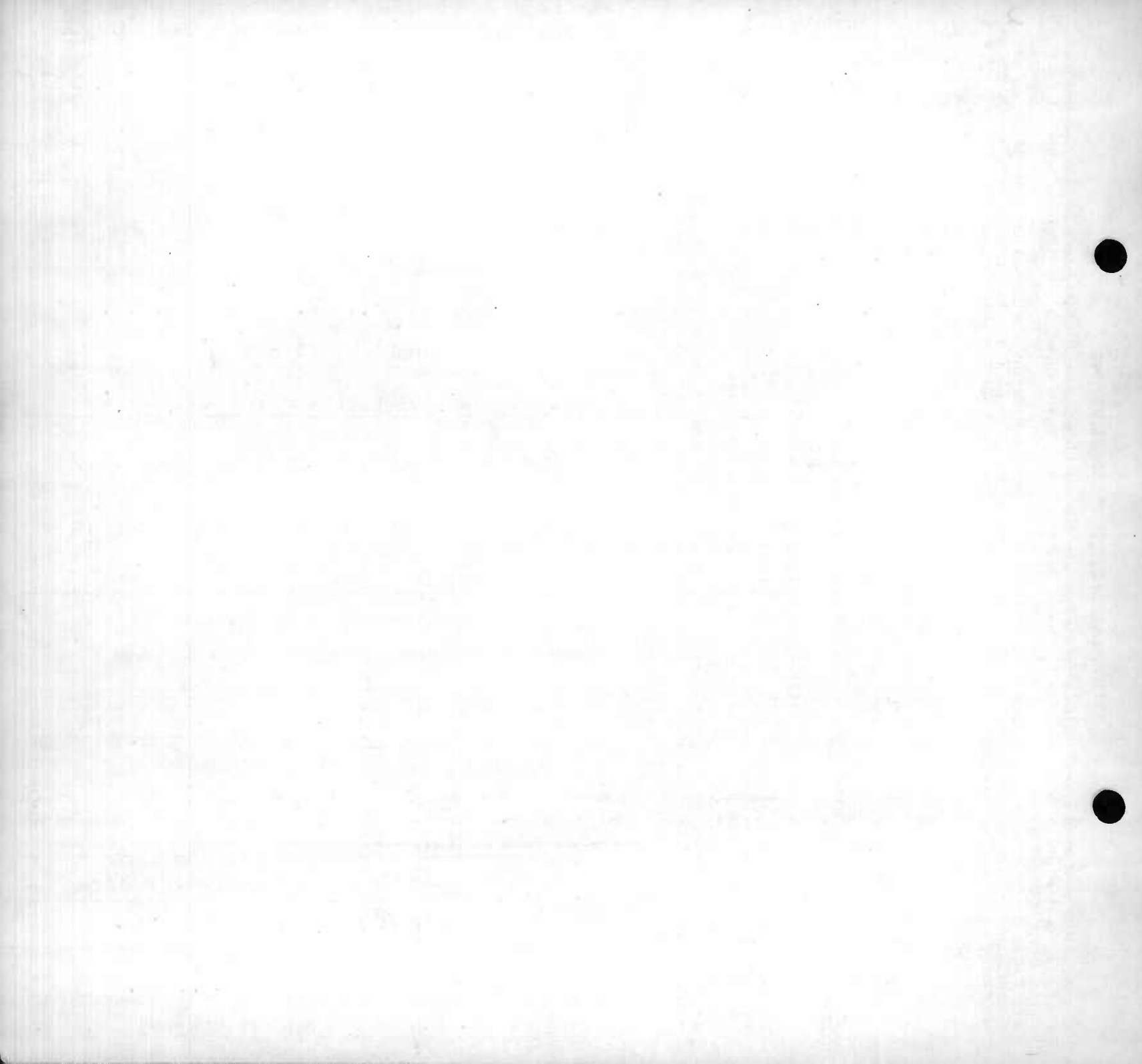
1. 10. 1941

1. 10. 1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

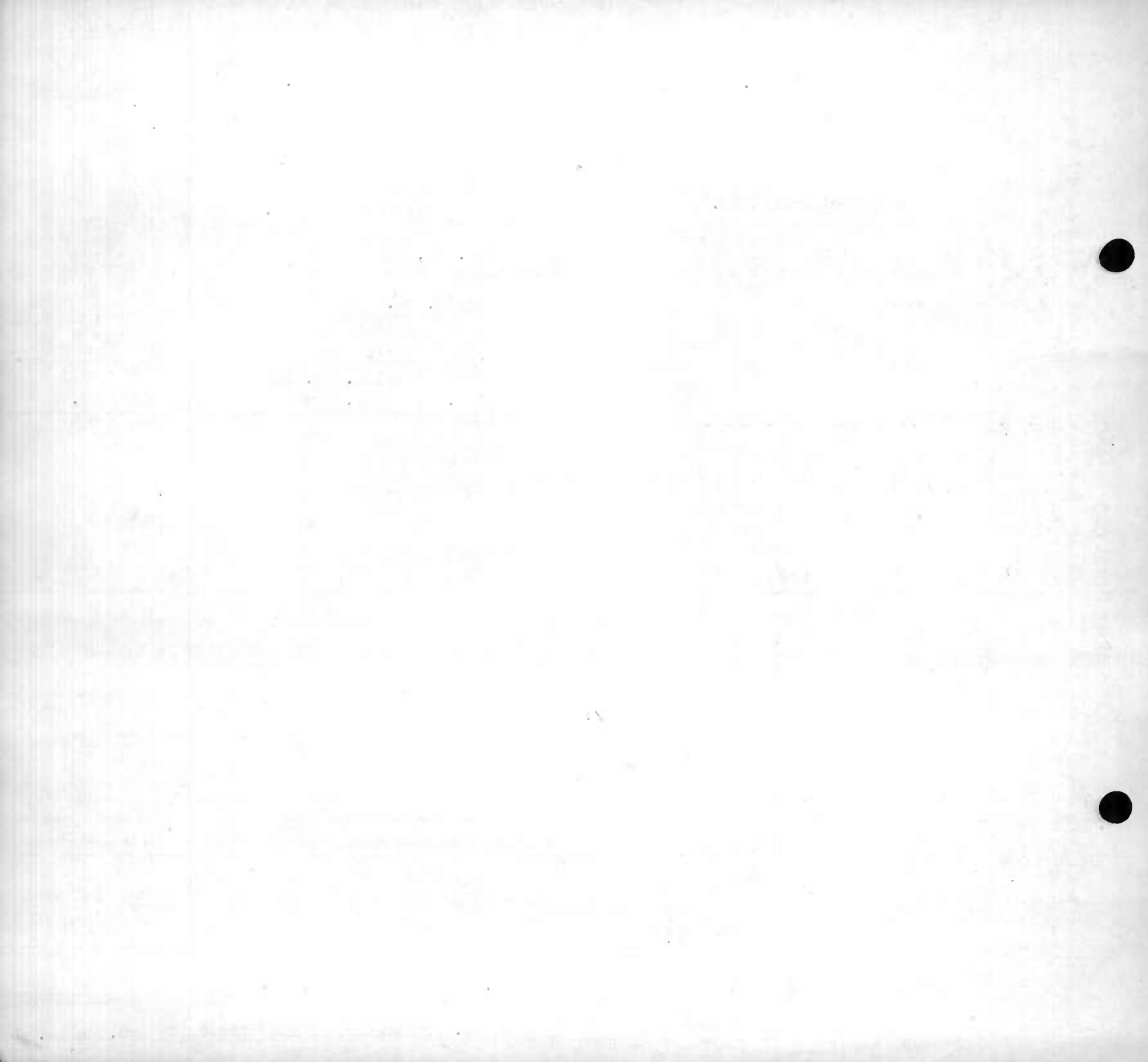
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06771		REGISTERED NO. 66 06771	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <i>Mauda V. Hobbs</i>				2. DATE AND HOUR OF DEATH <i>July 3, 1966 3:05 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Century Home, Inc.</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>402 102 N. Paca Street</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>March 15, 1878</i>	9. AGE (In years last birthday) <i>87</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>R.N.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>		11. BIRTHPLACE (State or foreign country) <i>Carroll Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Norval Hobbs</i>				14. MOTHER'S MAIDEN NAME <i>Josephine Gilbert</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-16-3969</i>		17. INFORMANT ADDRESS <i>3611 Essex Rd. Mrs. Ruth Lutz Baltimore, Md.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>422.14170X</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Carcinoma of left breast</i>				CAUSE OF DEATH (A) DUE TO <i>Arteriosclerotic cardiovascular disease</i> (B) DUE TO <i>Generalized arteriosclerosis</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>several years</i> <i>several years</i>	
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>July 2, 1966</i> to <i>July 3, 1966</i> , that (I) (we) last saw the deceased alive on <i>July 2, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Seymour H. Rubin</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>July 3, 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>Seymour H. Rubin</i>				23D. ADDRESS <i>5415 Park Heights Ave</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/6/1966</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Prospect Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Frederick Co., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 6 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairman</i>		25C. FUNERAL DIRECTOR ADDRESS <i>C. M. Waltz Box 241 Sykesville, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06772				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06772	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Katherine E. Green				2. DATE AND HOUR OF DEATH July 2, 1966 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 28-04			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4911 Briarclift Rd.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 4911 Briarclift Rd.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 26, 1894	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Frank Berger				14. MOTHER'S MAIDEN NAME Evelyn Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Balto. Md. 21229 Miss. Audrey E. Green 4911 Briarclift Rd.		ADDRESS
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Intermyocardial (VD)</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>not</u> 19 <u>43</u> to <u>July 2</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 1</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. C. POUND</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>July 4, 1966</u>	
23C. PHYSICIAN'S NAME (Type) J. C. POUND				23D. ADDRESS 3325 Frederick Ave. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 5, 1966		24C. NAME of CEMETERY or CREMATORY Lorrian Park Cem.		24D. LOCATION (City, town, or county) (State) Balto, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto.		ADDRESS Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CONRAD FRED HAETLER

2. DATE AND HOUR PRONOUNCED DEAD

1 July 1966

12:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2865 Chesterfield Ave.

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

February 19, 1895

9. AGE (In years
lost birth day)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

Friction Materials

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

August Haetler

14. MOTHER'S MAIDEN NAME

Anna Schmidt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mabel M. Haetler - 2865 Chesterfield Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and hypertensive
DUE TO cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/2/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-5-66

23C. NAME of CEMETERY or CREMATORY

Mount Olivet Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

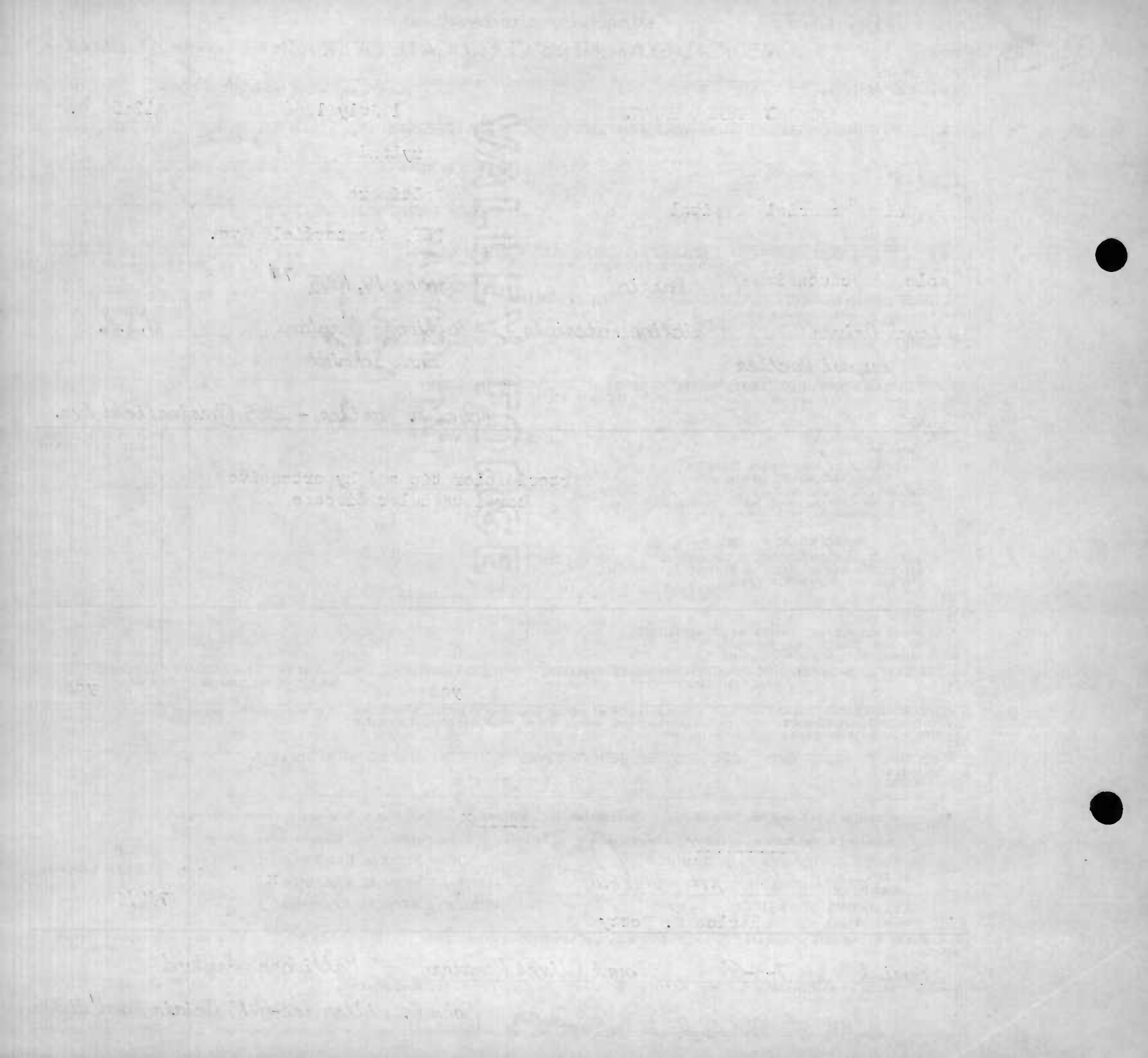
24C. FUNERAL DIRECTOR

ADDRESS

JUL 6 1966

Robert E. Farber

John C. Miller Inc-6415 Belair Road-21206



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06774		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06774	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Frieda A. Hutson			2. DATE AND HOUR OF DEATH July 3, 1966 3:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital			A. STATE Maryland B. COUNTY 103		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2711 Eastern Ave		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2/5/06	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Whiteharst			14. MOTHER'S MAIDEN NAME Bewig		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	17. INFORMANT Matilda LeBrum (Sister)		ADDRESS 506 S. Belmont Ave
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Chronic Bronchitis & Emphysema		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>June 24</u> 19 <u>66</u> to <u>July 3</u> 19 <u>66</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>July 3</u> 19 <u>66</u> and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE W. Michael Gould				23B. DATE SIGNED 7/3/66	
23C. PHYSICIAN'S NAME (Type) M.D.				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE July 6, 1966	24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Feltman	25C. FUNERAL DIRECTOR ADDRESS John C. Miller Inc-6415 Belair Road -21206		

W. Michael R. Kelly

July 3 2000

X

July 3 2000

No

Class: Business English

Atlanta-CUAD

Miscellaneous / Information

Westwood / Fidelity

No

Bullman / Information

Beard

Westwood / Fidelity

2000

Westwood / Fidelity

Westwood

5/8/00

20

Westwood / Fidelity

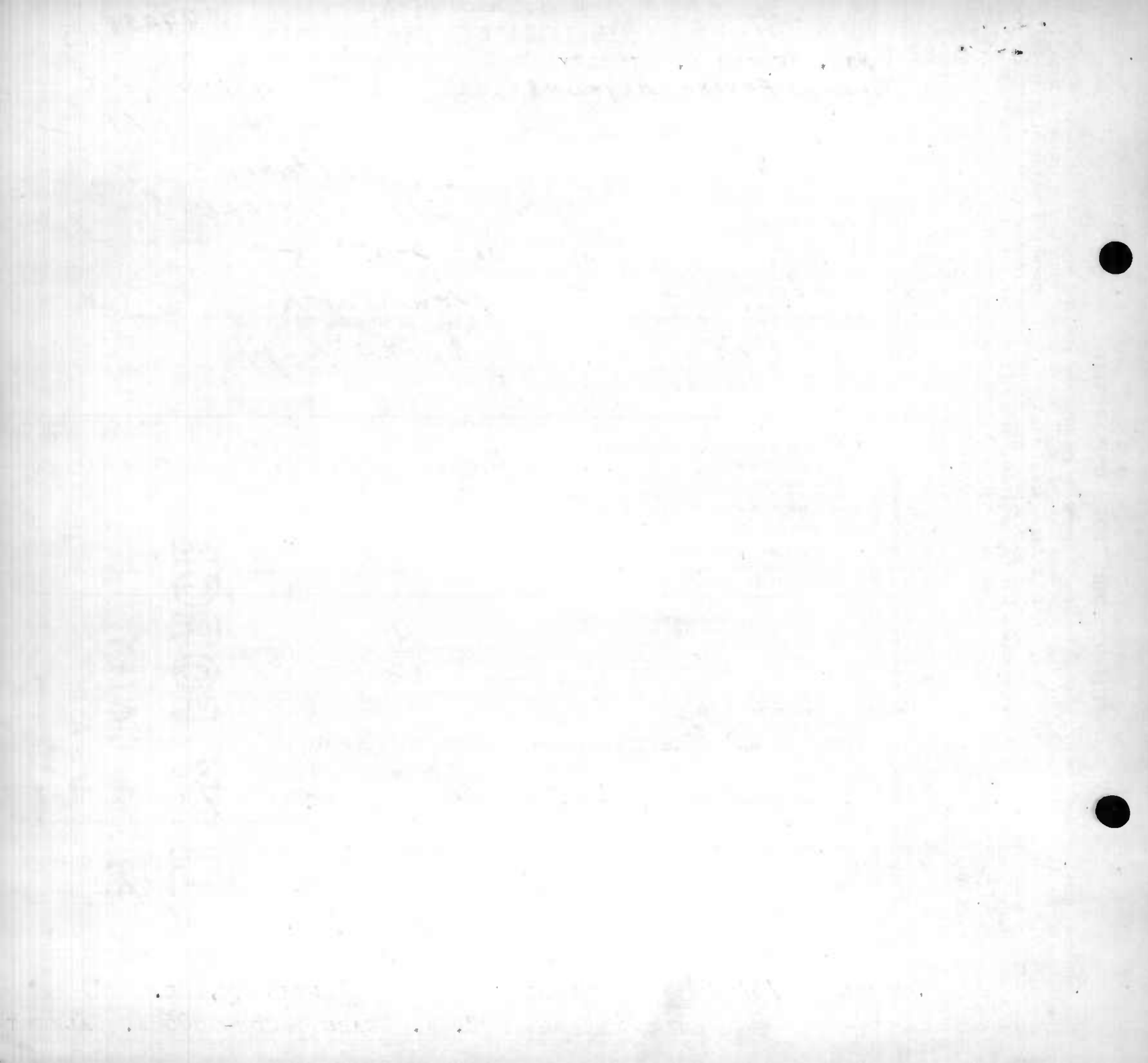
Bullman

2000 Eastern Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 77038	
BIRTH NO. 66 06775		CERTIFICATE OF DEATH			
M.E. CASE NO. 66 06775		1. NAME OF DECEASED (Type or Print) Mrs. FEDORA A. TINSLEY <i>TINSLEY, FEDORA Angelina</i>		2. DATE AND HOUR OF DEATH <i>4:55 7/1/66 11:55 P</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Balt. B. COUNTY 1102			
FULL NAME OF HOSPITAL OR INSTITUTION <i>36 Franklin Square Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 514 Cathedral St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-22-07	9. AGE (in years lost birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Adolph Chiappa		14. MOTHER'S MAIDEN NAME Anita Volpi		17. INFORMANT ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown			
18. 237X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Brain Tumor		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH unknown	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1-6-29		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diagnostic Purposes		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/14 19 66 to 7/1 19 66 , that (I) (we) last saw the deceased alive on 7/1 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. S. Magno		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/2/66	
23C. PHYSICIAN'S NAME (Type) RAYMUNDO S. Magno		23D. ADDRESS Franklin Square Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7/5/66	24C. NAME of CEMETERY or CREMATORY CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS H. W. MEARS & SON - 805 N. CALVERT	



K-530

66 06776

BALTIMORE CITY HEALTH DEPARTMENT

66 06776

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNA

KENT

2. DATE AND HOUR PRONOUNCED DEAD

July 4, 1966

9:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

612 School Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

612 School Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

5-4-20

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jessie Cooper

14. MOTHER'S MAIDEN NAME

Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Celeste Boyer 1124 Stockton St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Epilepsy
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

July 4, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-4-66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 6 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Geo. G. Nelson 1548 Calhoun St.

ADDRESS

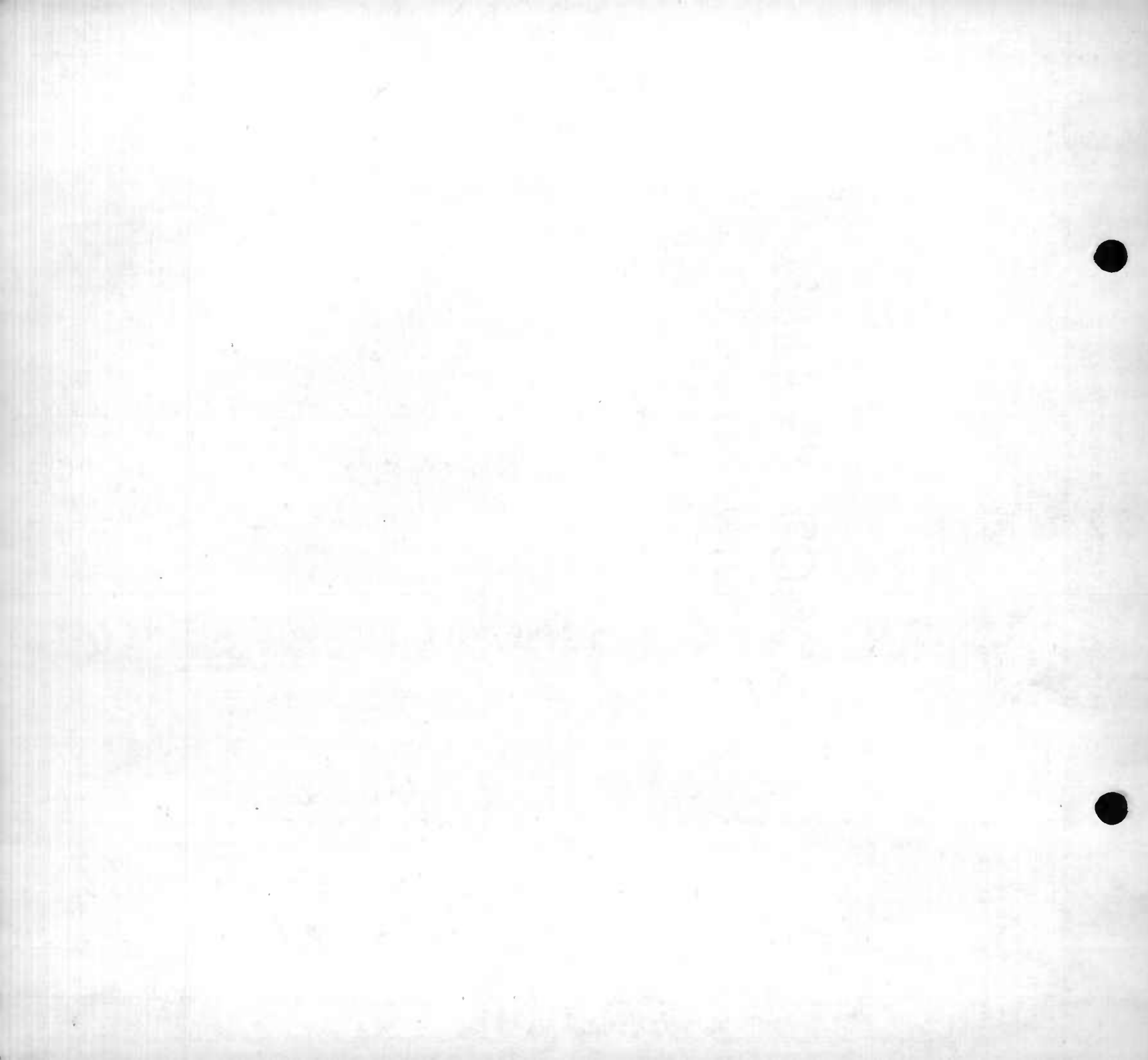
VALLEY FOLIO

RAILROAD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) A fracture of any kind; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed at final disposition is made.

Baltimore City Health Department				Registered No. 66 06777	
BIRTH NO.		66 06777		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WALLACE Smith		2. DATE AND HOUR OF DEATH 7/2/66 11:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 15-11		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT Hospital		D. STREET ADDRESS (If rural, give location) 3209 Sequoia Ave.		5. SEX Male 6. RACE NEGRO 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 10/4/00		9. AGE (In years last birthday) 65		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - watchman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Squire Smith		14. MOTHER'S MAIDEN NAME MARY E. Johnson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 216-102468		17. INFORMANT Chart - Hospital, Provident	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 443X & 260X		CAUSE OF DEATH (A) DUE TO Cerebrovascular Accident (B) DUE TO Arteriosclerosis & HCU (C) _____		INTERVAL BETWEEN ONSET AND DEATH 10 days At least 3 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus		10 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/22 1966 to 7/2 1966 , that (I) (we) lost saw the deceased alive on 7/2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elijah Saunders		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/3/66	
23C. PHYSICIAN'S NAME (Type) ELIJAH SAUNDERS		23D. ADDRESS 3414 DUVALL Ave; BALTO, MD 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-66		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.	
24D. LOCATION (City, town, or county) (State) Arbutus Maryland		25A. DATE RECEIVED BY HEALTH DEPT. JUL 6 1966			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Geo. D. Nelson 1348 Calhoun St.			



1
K-520

66 06778

BALTIMORE CITY HEALTH DEPARTMENT

66 06778

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES

KING

2. DATE AND HOUR PRONOUNCED DEAD

July 3, 1966

10:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

608 Gold Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

608 Gold Street

5. SEX

Male

6. RACE

Male

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

12-6-04

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert King

14. MOTHER'S MAIDEN NAME

Maggie Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Hilda King 608 Gold Street

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive arteriosclerotic
~~XXXXXX~~ cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
July 4, 196623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-7-66

23C. NAME of CEMETERY or CREMATORY

Carroll Cemetery

23D. LOCATION

(City, town, or county)

(State)

Carroll County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 8 1966

R. S. Fisher, M.D.

George G. Nelson 1348 Calhoun St.

WALLACE BOWEN

1
M-400

66 06779

BALTIMORE CITY HEALTH DEPARTMENT

66 06779

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CLARA E. MUHLY		2. DATE AND HOUR PRONOUNCED DEAD 2 July 1966 7:10 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 29 E. West St.	
5. SEX female	6. RACE caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH April 2, 1872
9. AGE (In years last birthday) 94		10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl O. Enge		14. MOTHER'S MAIDEN NAME Emma Richter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		ADDRESS Same	
18. CAUSE OF DEATH 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO (A)..... (B)..... (C)..... INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/3/66	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7/6/66	
23C. NAME OF CEMETERY or CREMATORY Emmanuel Luth. Cem.		23D. LOCATION (City, town, or county) (State) Baltimore 14, Md.	
24A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		24B. NAME OF REGISTRAR Robert E. Farley	
24C. FUNERAL DIRECTOR McCully Funeral Home		ADDRESS 130 E. Fort Ave.	

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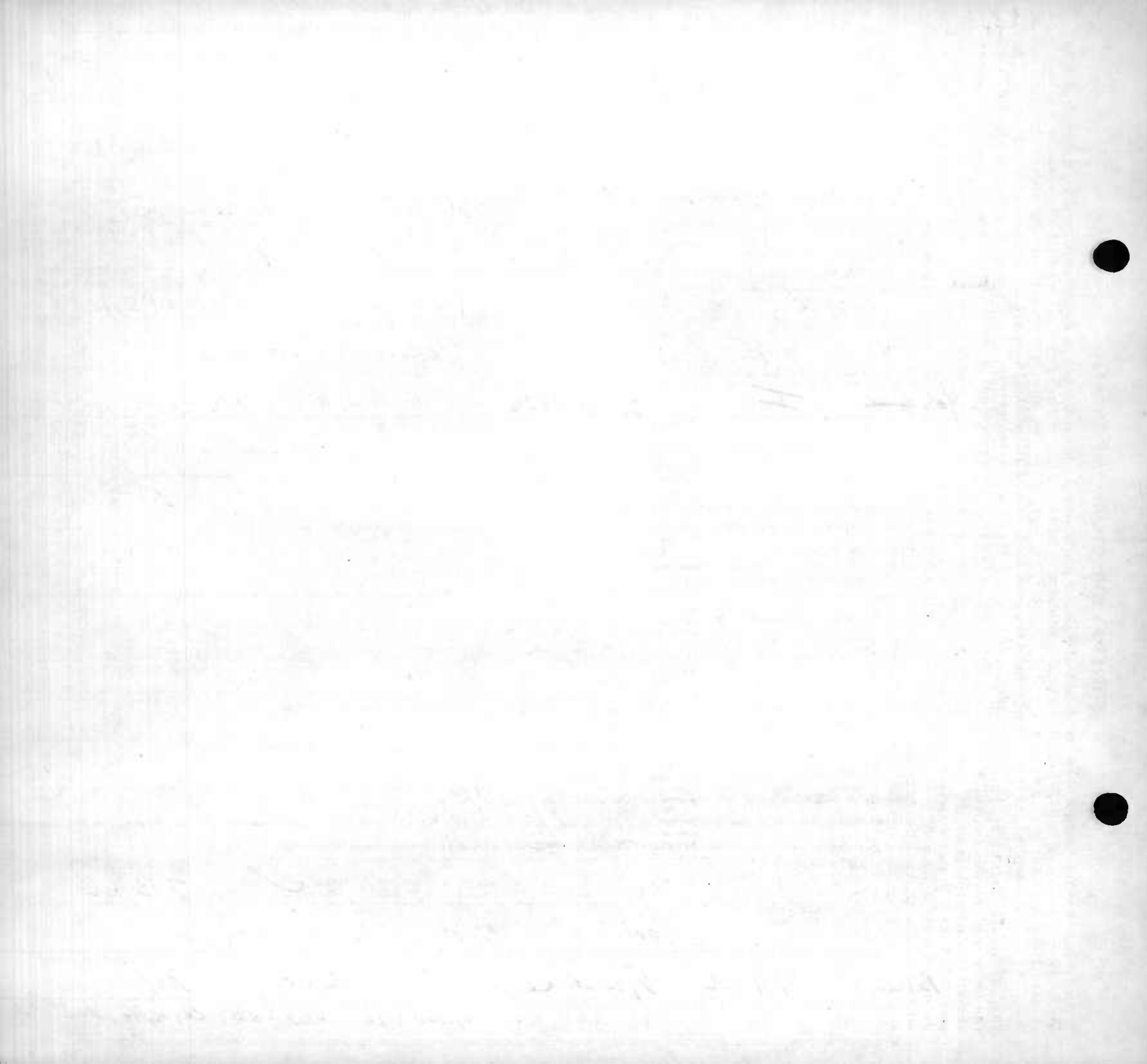
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06780				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06780	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SAMUEL B. MILMAN				2. DATE AND HOUR OF DEATH 7/3/66 10³⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSP.		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 11-03	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 306 W. FRANKLIN ST.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED DIVORCED	8. DATE OF BIRTH 2/9/97	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HYMAN MILMAN				14. MOTHER'S MAIDEN NAME REBECCA CORNBLATT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES NO I		16. SOCIAL SECURITY NO. 215-10-7876		17. INFORMANT ADDRESS L.O. OLSEN, MD - MD GEN'L HOSP			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PULMONARY EDEMA				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARDIAC HYPERTROPHY (L VENTRICLE) CALCIFIC + RHEUMATIC AORTIC STENOSIS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 7/3 1966 to 7/3 1966 , that (I) last saw the deceased alive on 7/3 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE Louis O. Olsen				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/3/66	
23C. PHYSICIAN'S NAME (Type) LOUIS O. OLSEN				23D. ADDRESS Med. GEN'L Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/1966		24C. NAME OF CEMETERY or CREMATORY Rosevale		24D. LOCATION (City, town, or county) (State) Belts. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR SYLVAN S. LEWIS + SON - 3319 ALYMPIA AVE		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. 66 06781		CERTIFICATE OF DEATH		Registered No. 66 06781	
1. NAME OF DECEASED (Type or Print) James A. Fisher				2. DATE AND HOUR OF DEATH July 2/66 at 11 p.m. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore 53-00 C. CITY OR TOWN (If outside city limits, write RURAL and give township) DUNDALK D. STREET ADDRESS (If rural, give location) 21 Liberty Pkwy 6838 DUNBAR Rd			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 11-2-88	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - V.S. Govt			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? American
13. FATHER'S NAME Peter J. Fisher			14. MOTHER'S MAIDEN NAME Mary Hill				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO. 218 22 0483		17. INFORMANT ADDRESS CHURCH HOME HOSPTL.		
18. 584X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarct. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. cholecistectomy				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH three days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 6-30-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED cholelithiasis		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 2 19 66 to July 2 19 66 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. R. Anderson M.D.				23B. DATE SIGNED July 2/66		23C. PHYSICIAN'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE July 6, 66		24C. NAME OF CEMETERY or CREMATORY OAK LAWN	
24D. LOCATION (City, town, or county) (State) BALTO. CO., Md.				25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR LeBron Bradley, Realtor, Md.				25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 06782					CERTIFICATE OF DEATH					Registered No. 66 06782				
1. NAME OF DECEASED (Type or Print) HALSTED, ALFRED THOMAS					2. DATE AND HOUR OF DEATH 7/3/66 11:35 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE									
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL BALTIMORE, Md.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE SPARROWS POINT									
D. STREET ADDRESS (If rural, give location) 903 E. ST.														
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 9-15-93		9. AGE (In years last birthday) 72		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MASTER MECH.					10B. KIND OF BUSINESS OR INDUSTRY MA STEEL MFG. R.					11. BIRTHPLACE (State or foreign country) MD.				
12. CITIZEN OF WHAT COUNTRY? USA.					13. FATHER'S NAME ALFRED HALSTED					14. MOTHER'S MAIDEN NAME HANNAH HERGESHIMER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -					16. SOCIAL SECURITY NO. 213-07-0179					17. INFORMANT ADDRESS CHURCH HOME HOSPITAL				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebro vascular accident days.										INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 7-2-66 19 to 7-3-66 19 that (I) (we) last saw the deceased alive on 7-3 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE E. MARIANO										23B. DATE SIGNED 7-3-66				
23C. PHYSICIAN'S NAME (Type) E. MARIANO										23D. ADDRESS CHURCH HOME & HOSPITAL BALTIMORE, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 7/6/1966					24C. NAME OF CEMETERY or CREMATORY LOUDON PARK				
24D. LOCATION (City, town, or county) (State) BALTO, Md.														
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966					25B. NAME OF REGISTRAR R. E. F. J. F. J.					25C. FUNERAL DIRECTOR ADDRESS 1212 N. Broadway, Baltimore, Md.				

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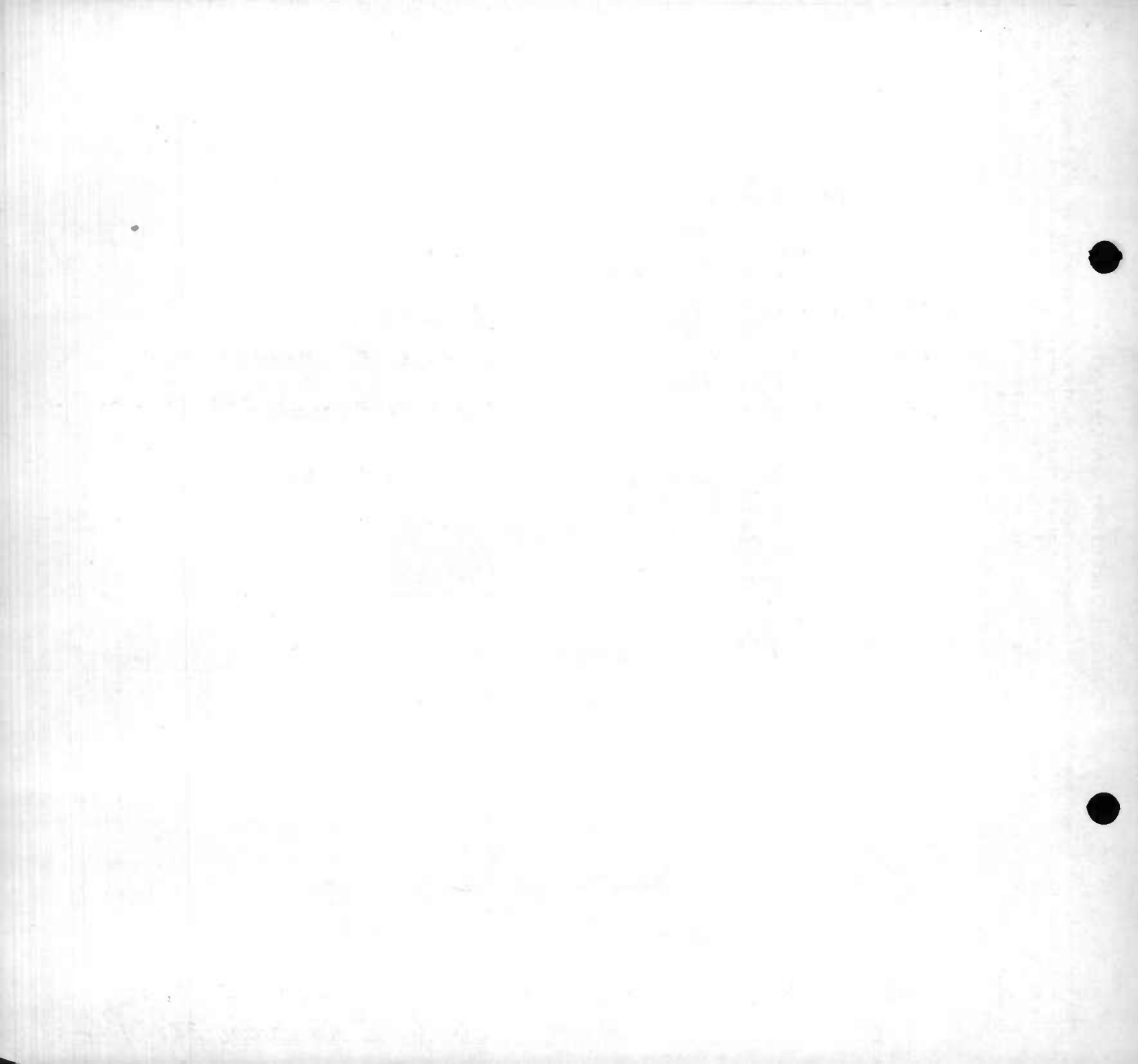
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 06783	
BIRTH NO. 66 06783										CERTIFICATE OF DEATH	
M.E. CASE NO.										DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) HARRY MILLER										7/2/66 10 ⁰⁰ PM 10 ⁰⁰ P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore										A. STATE md. B. COUNTY 13-06	
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
										D. STREET ADDRESS (If rural, give location) 821 Powers St.	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED		8. DATE OF BIRTH 1-15-17	9. AGE (In years lost birthday) 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PLUMBER				10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME HARRY MILLER				14. MOTHER'S MAIDEN NAME CARRIE F. HORNBERGER							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1st W.W.				16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS DORIS M. ARNOLD-3430 CHESTNUT AVE					
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) Acute Pulmonary Edema DUE TO (B) Acute Myocardial Infarction DUE TO (C) 4 hours within 24 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Jan 2 19 62 to July 2 19 66 , that (I) (we) last saw the deceased alive on July 2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Leonard Wallenstein M.D.								23B. DATE SIGNED 7/2/66			
23C. PHYSICIAN'S NAME (Type) Leonard Wallenstein M.D.								23D. ADDRESS Sinai Hosp.			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 7/6/66		24C. NAME of CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Windsor Mill Rd, Md					
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR R. E. Farkner		25C. FUNERAL DIRECTOR Austin E. Donovan		ADDRESS 3818 Roland Park					

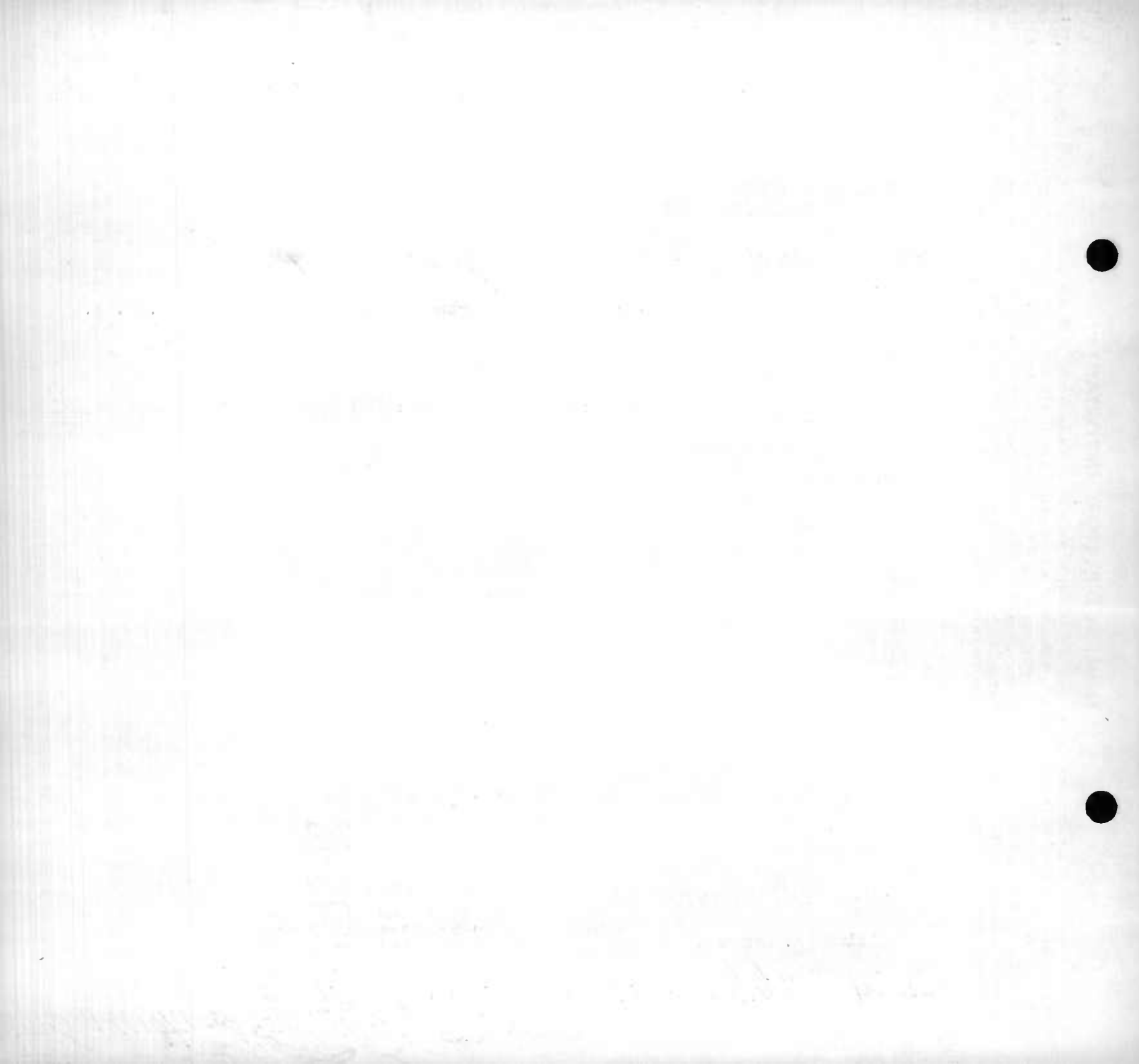


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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

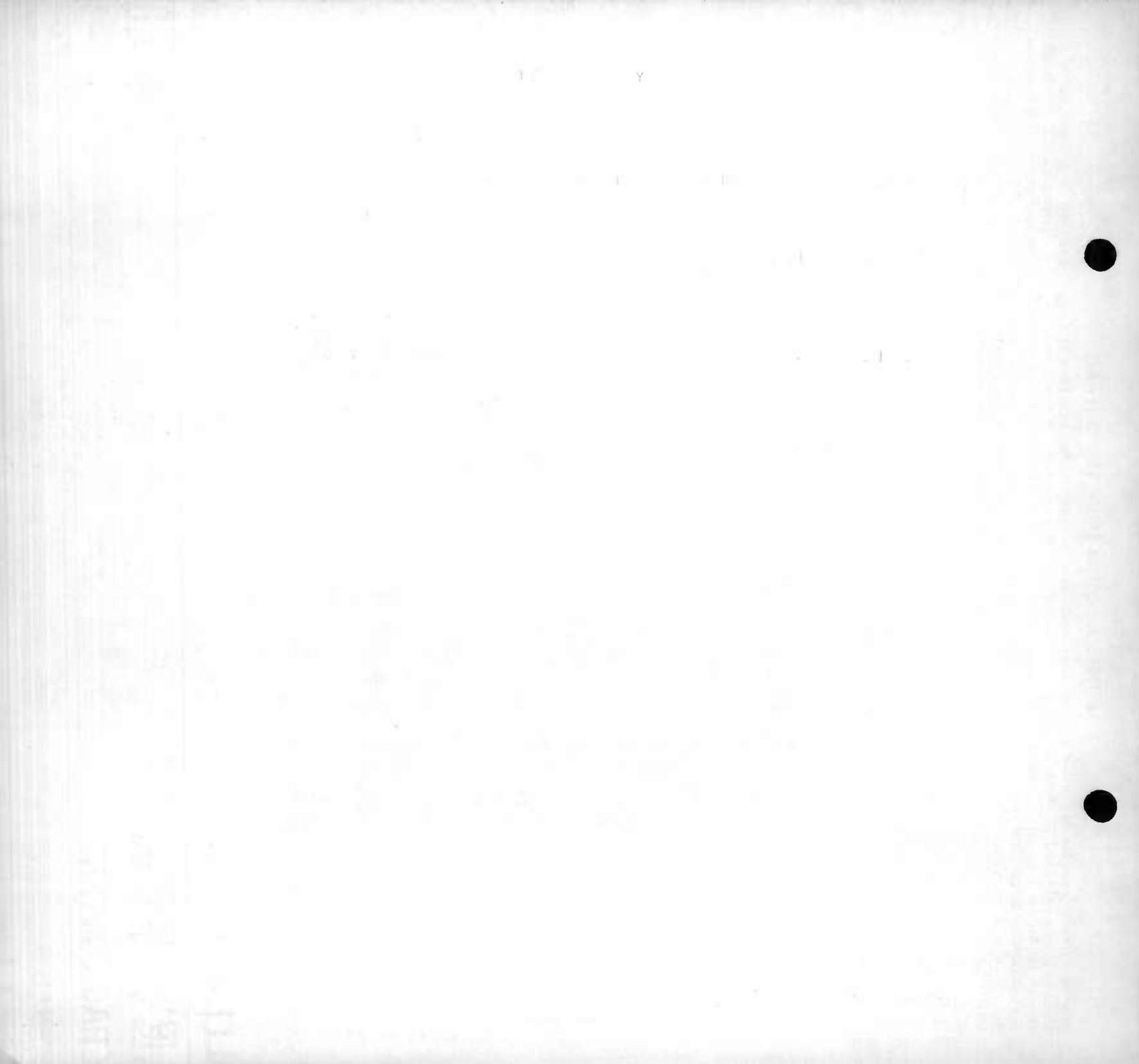
BIRTH NO. 66 06784		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06784	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mallie Hicks</u>		2. DATE AND HOUR OF DEATH <u>6/30/66</u> <u>11 30 P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>14-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND 21224</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>21217 007</u>			
		D. STREET ADDRESS (If rural, give location) <u>1711 Bolton Street</u>			
5. SEX <u>Female</u>	6. RACE <u>N Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>June 23/1919</u> <u>47</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Cola Young</u>			
14. MOTHER'S MAIDEN NAME <u>Lucille Stevenson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT ADDRESS <u>RECORDS: BCH 4940 EASTERN AV ENUE #21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cor Pulmonale</u> <u>Systemic Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>~ 2 years</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>NO</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/19/66</u> 19 to <u>6/30</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6/30/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Wm. A. Emerson</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/30/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>William A. Emerson</u>		23D. ADDRESS M.D. <u>4940 EASTERN AVENUE #21224</u> <u>BALTIMORE CITY HOSPITALS</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/6/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Wt. Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Chittman</u>			
25D. ADDRESS <u>Balto. Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06785				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06785	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
RUBY BRACKETT				7-4-66		6:15 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				602 N HIGHLAND AVENUE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
FEMALE	WHITE	MARRIED	12-12-15	50			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Kentucky			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
OLLIE MAX				SUE TAYLOR			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		216-31-9423		William G. Brackett		602 N. Highland Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) RHEUMATIC HEART DISEASE			
ANTECEDENT CAUSES				DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				mitral stenosis			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				yes		no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from July 2, 1966 to July 4, 1966, that (I) (we) last saw the deceased alive on 6:20 July 4, 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Tah-Hsiung Hsu M.D.				7/4/66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Tah-Hsiung Hsu M.D.				The Johns Hopkins Hospital			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		July 8, 1966		Baltimore Nat. Cem.		Baltimore	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
July 10, 1966		Robert E. Taylor, M.D.		Philip Hewing Sons		2024 Collins St #31	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE AMENDED

BIRTH NO. 13 192 2543E0 JOHN		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06786	
M.E. CASE NO. WEIR, MORRIS JAMES		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) WEIR, MORRIS JAMES		2. DATE AND HOUR OF DEATH 7/3/66 6:35 PM		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND The Union Memorial Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Balto		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 3370	
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Louis MO.	
13. FATHER'S NAME JAMES WEIR		14. MOTHER'S MAIDEN NAME MARY Mc GOWAN		12. CITIZEN OF WHAT COUNTRY? American	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 29 1966 to July 3 1966, that (I) (we) last saw the deceased alive on 6:35 PM 7/3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sun Young Choi		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 3, 1966	
23C. PHYSICIAN'S NAME (Type) SUN YOUNG CHOI		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/6/66		24C. NAME of CEMETERY or CREMATORY ST. JOHNS	
24D. LOCATION (City, town, or county) HOWARD CO. MD		(State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR R. E. Farley		25C. FUNERAL DIRECTOR E. S. MALNABB 301 FREDERICK RD 21228	

US 153- 7/15/64

08/20/61

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 06787				
BIRTH NO. 66 06787									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) ANNA AMELIA SHALLER					2. DATE AND HOUR OF DEATH 7-1-66 8:25P.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD. 21205					A. STATE MARYLAND B. COUNTY BALTIMORE				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 511 OLD NORTH POINT ROAD				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 9-28-81	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JAMES JANUSHEK					14. MOTHER'S MAIDEN NAME UNKN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 218-01-9549		17. INFORMANT Betty Cadden, dght.		ADDRESS #21224 503 Old North Pt.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES					(A) DUE TO Cardiogenic shock			1 day	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO Hypertensive cardiovascular disease			years	
					(C)				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7/1/66 to 7/1/66, that (I) (we) last saw the deceased alive on 7/1/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Harmon J Eyre					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 7/1/66	
23C. PHYSICIAN'S NAME (Type) Harmon J Eyre					23D. ADDRESS M.D. 550 N. Broadway Baltimore Md				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/66		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane			ADDRESS	

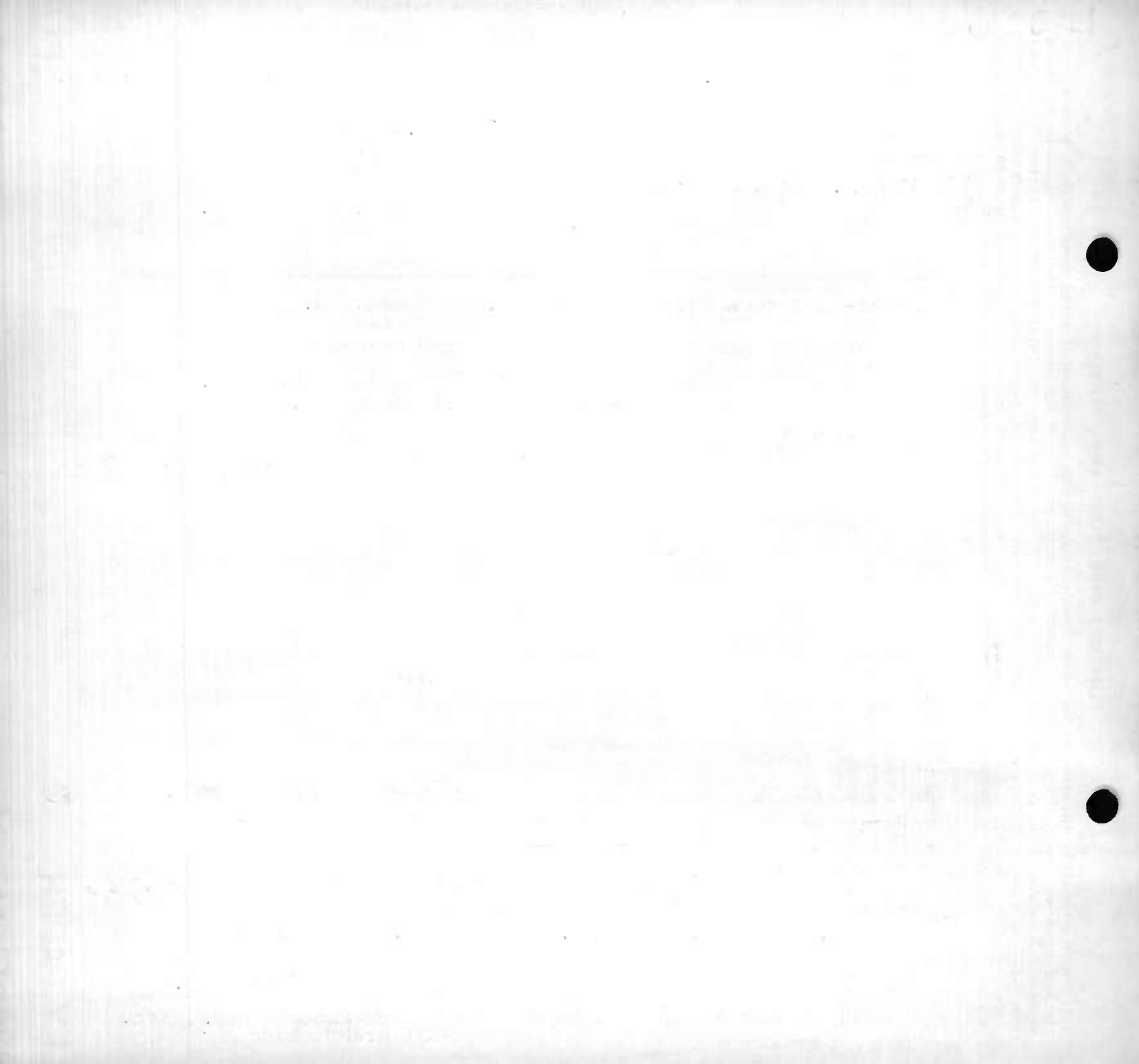
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 06788</u>	
BIRTH NO. <u>66 06788</u>		M.E. CASE NO. <u>64-12820</u>		1. NAME OF DECEASED (Type or Print) <u>SHEILA ANITA MAULTSBY</u>		2. DATE AND HOUR OF DEATH <u>7-4-66</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>8-02</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO.</u>			
				D. STREET ADDRESS (If rural, give location) <u>1917 N. PATTERSON PK. AVE.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>INFANT</u>		8. DATE OF BIRTH <u>5-19-64</u>	9. AGE (In years last birthday) <u>2</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, <u>even if retired</u>)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LENNON MAULTSBY</u>				14. MOTHER'S MAIDEN NAME <u>MARGARETTA MAULTSBY ROBINSON</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>V. D. Hunt # 311163</u> ADDRESS			
18. <u>309X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>Chronic Brain Syndrome</u> (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>0</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>the</u> (this hospital) attended the deceased from <u>7-3</u> 19 <u>66</u> to <u>7-4</u> 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>7-4</u> 19 <u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>We</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>Albert M. Gordon</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7/8/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALBERT M. GORDON</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/8/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE NATIONAL</u>		24D. LOCATION (City, town, or county) (State) <u>5500 Frederick Ave Balto</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairley, MA</u>		25C. FUNERAL DIRECTOR <u>Ronald E. Glower 1701-03 Patterson</u>			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

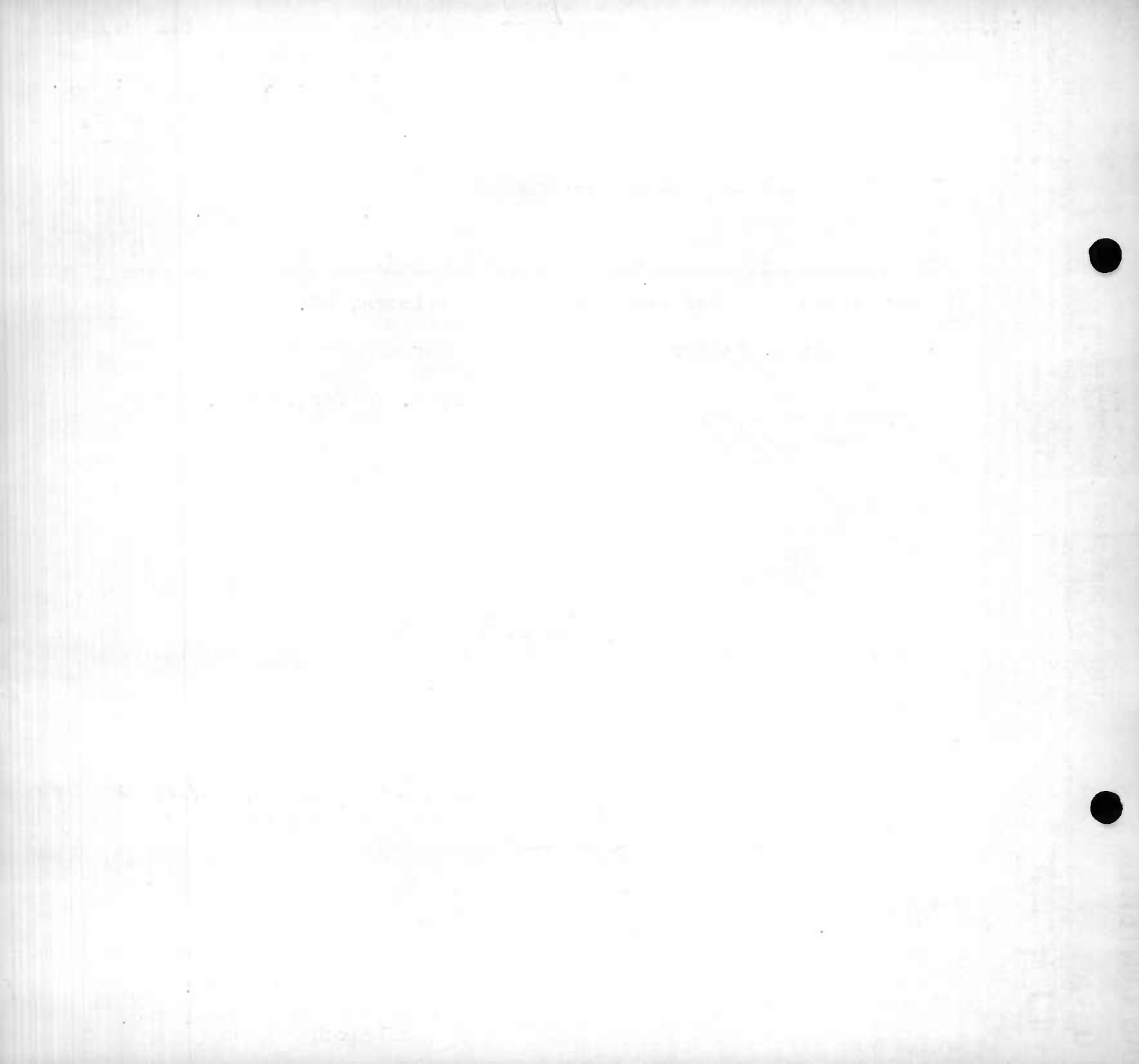
BIRTH NO. 66 06789		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06789	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE M. HUGHES		2. DATE AND HOUR OF DEATH July 4, 1966 2:45 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1203 N. Charles Street		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md., 21201 B. COUNTY 1102 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1203 N. Charles St.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 12/4/1895	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leader-tool room		10B. KIND OF BUSINESS OR INDUSTRY Beth Steel		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Michael Hughes			
14. MOTHER'S MAIDEN NAME Mary Frances Ochs		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 215-05-5354		17. INFORMANT 2850 Pelham Ave. Cecilia Hughes, sister, ADDRESS			
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Arteriosclerosis C.V. Dis.</i> DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>uncertain</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/15 1961 to 7/4 1966, that (I) (we) last saw the deceased alive on 5/20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lester A. Wall Jr.</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/5/66	
23C. PHYSICIAN'S NAME (Type) Dr. Lester A. Wall, Jr.		23D. ADDRESS M.D. 1039 St. Paul Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/66		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE RECEIVED BY HEALTH DEPT. JUL 6 1966			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane			



FUNERAL DIRECTOR: IMPORTANT

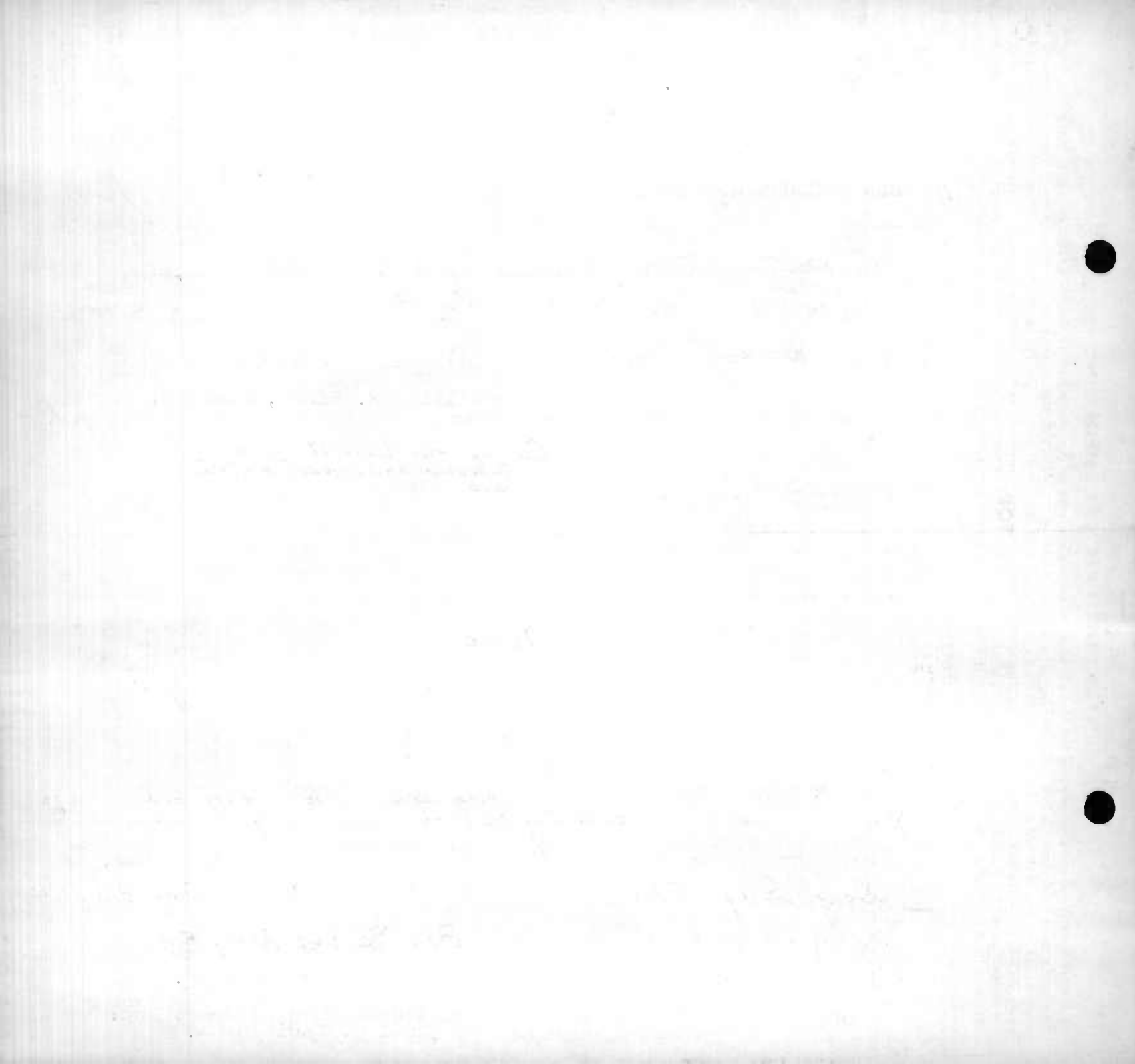
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06790	
BIRTH NO. 66 06790		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CATHERINE KAIFER		2. DATE AND HOUR OF DEATH July 2, 1966 8:15 p. m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Harford Gardens Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 21224 B. COUNTY 1-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 500 S. Kenwood Ave.			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH 5/12/1888	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY self-employed		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Albert A. Kaifer			14. MOTHER'S MAIDEN NAME Barbara Schmidt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mary A. Kaifer, sister, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 493X+260X Pneumonia		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 29 1966 to July 2 1966 , that (I) (we) last saw the deceased alive on July 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Loy M. Zimmerman M.D.				23B. DATE SIGNED 7/5/66	
23C. PHYSICIAN'S NAME (Type) Dr. Loy Zimmerman		23D. ADDRESS 3202 Harford Road M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/66		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06791</u>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <u>66 06791</u></p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>Mrs. Rita A. Pfaff</u></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <u>July 3 1966 9⁰⁰ P.M.</u></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BON SECOURS HOSPITAL</u></p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore, Md., 21205</u></p> <p>D. STREET ADDRESS (If rural, give location) <u>825 N. Luzerne Ave</u></p>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12/1/931</u>	9. AGE (In years lost birthday) <u>44</u>	<p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u></p>			<p>10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u></p>		
<p>11. BIRTHPLACE (State or foreign country) <u>Baltimore, Mo</u></p>			<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		
<p>13. FATHER'S NAME <u>Frank Nemec</u></p>			<p>14. MOTHER'S MAIDEN NAME <u>Anna Doluka</u></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>			<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS <u>William R. Pfaff, husband, above</u></p>
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ca. of the Lung Lt with cerebral and heart metastases</u></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>None</u></p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <u>No</u></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City give exact location) <u>Yes</u></p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (X) (this hospital) attended the deceased from <u>May 28th</u> 19<u>66</u> to <u>July 3rd</u> 19<u>66</u>, that (X) (we) last saw the deceased alive on <u>20:30 July 3rd</u> 19<u>66</u> and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Dong Sup Cha</u></p>					<p>23B. DATE SIGNED <u>July 3rd 1966</u></p>
<p>23C. PHYSICIAN'S NAME (Type) <u>Dong Sup Cha</u></p>			<p>23D. ADDRESS <u>Bon Secours Hospital</u></p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>7/7/66</u></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u></p>	
<p>24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u></p>					
<p>25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1966</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Farley</u></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <u>Schimunek Funeral Home, Inc. 2601 E. Madison St.</u></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06792</u>	
BIRTH NO. <u>66 06792</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>APOLONIA (PAULINE) LANIEWSKI</u>		2. DATE AND HOUR OF DEATH <u>4 JULY 66</u> <u>125</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE (508 S. Washington St.)</u>			
		D. STREET ADDRESS (If rural, give location) <u>2926 HARFORD RD</u> <u>HARFORD GUANT</u> <u>House Inc</u>			
5. SEX <u>F</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>3-4-84</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>	11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>? U.S.</u>
13. FATHER'S NAME <u>UNKNOWN (213-10-6427A)</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT ADDRESS <u>Mrs. Martha Lane, 2026 E. Lombard St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>331X I</u>		CAUSE OF DEATH (A) <u>CEREBRAL VASCULAR ACCIDENT 12 hr.</u> DUE TO (B) <u>BRONCHIAL PNEUMONIA</u> DUE TO (C) <u>GENERALIZED ARTERIO SCLEROSIS</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>DEHYDRATION</u>			
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JULY 1</u> 19 <u>66</u> to <u>JULY 4</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>JULY 4</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sidney E. Kirkley</u>				23B. DATE SIGNED <u>4 JULY 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>SIDNEY E. KIRKLEY</u>		23D. ADDRESS <u>UNION MEMORIAL Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/7/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Rosary</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, Jr.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>M.F. SADOWSKI & SONS, 1808 EASTERN AVE</u>	

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66 06793

BALTIMORE CITY HEALTH DEPARTMENT

66 06793

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH MERVINE

2. DATE AND HOUR PRONOUNCED DEAD

July 1, 1966

1:45 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Pennsylvania

B. COUNTY

Delaware

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Chester

D. STREET ADDRESS (If rural, give location)

816 East 14th Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

NEVER Married

8. DATE OF BIRTH

Feb. 26, 1945

9. AGE (In years
last birthday)

21

10. Under 1 Yr. 11. Under 24 Hrs.
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

P/c U.S.A.

10B. KIND OF BUSINESS OR INDUSTRY

U.S.A.

11. BIRTHPLACE (State or foreign country)

Upland, Penna.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Mervine

14. MOTHER'S MAIDEN NAME

Lilly Mae Kain

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

9/4/65 to 7-1-66

16. SOCIAL
SECURITY NO.

205-34-206

17. INFORMANT

Mr. Harry Mervine 816 E 14th St. Chester PA

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Multiple injuries

(A).....
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Race Road and Golden Ring Road

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 1 66 1:08A.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto that struck tree

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-1-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-7-66

23C. NAME of CEMETERY or CREMATORY

Lawn Crest Cem.

23D. LOCATION

(City, town, or county)

(State)

Boothwyn, Del. Co., PA.

24A. DATE REC'D BY HEALTH DEPT.

JUL 6

1966

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Wm. S. Bleyer 500 W. 22nd St. Chester, Pa.

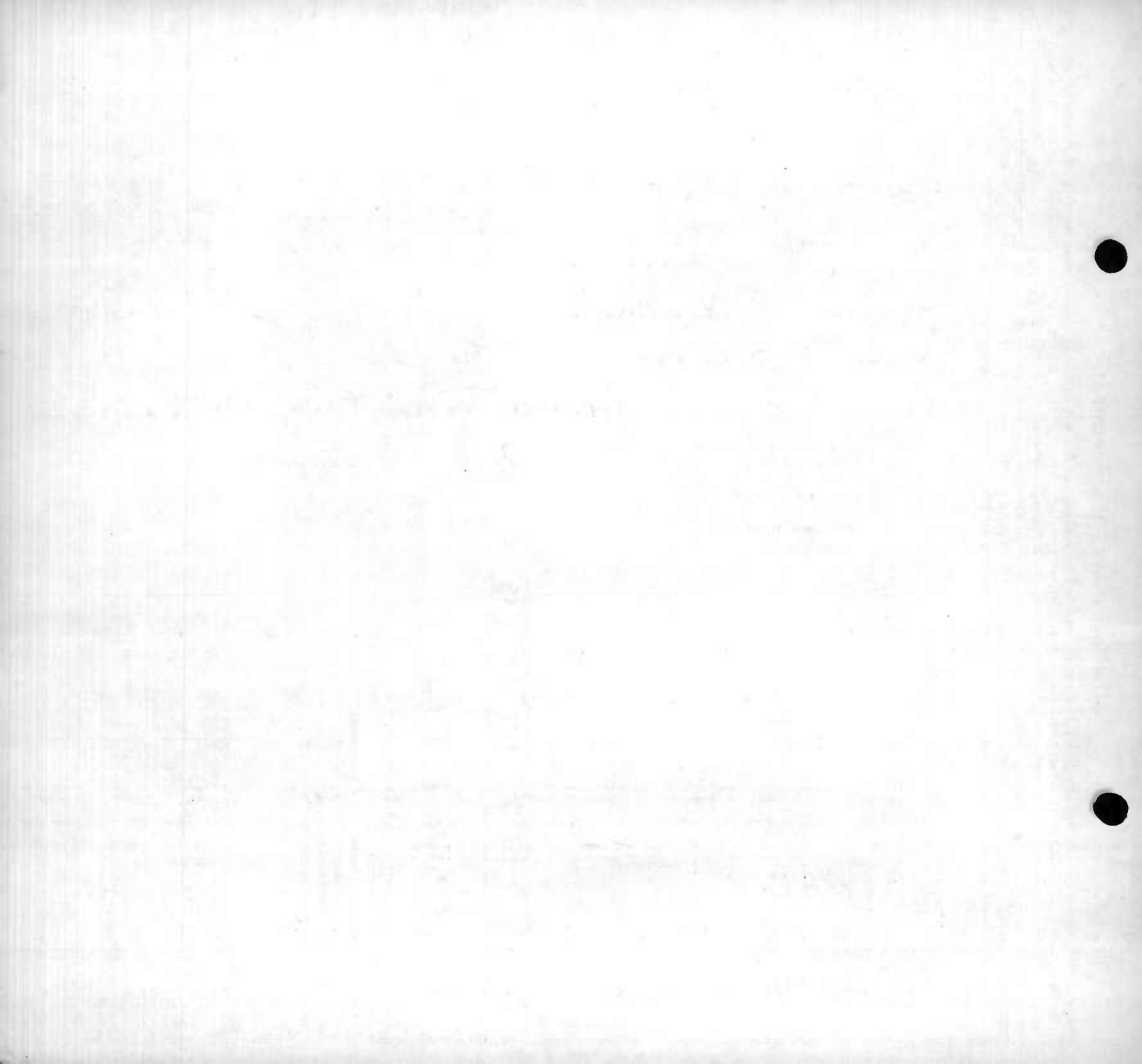
ADDRESS

VALLEY FORD

DEPT. OF JUSTICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06794				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06794	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN F. CLARY				2. DATE AND HOUR OF DEATH 7/3/66 5 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Ind. B. COUNTY 18-03			
FULL NAME OF HOSPITAL OR INSTITUTION 934 Lemmon St.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 934 Lemmon St - Zone 21223			
5. SEX M.	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 4/1/1900	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10B. KIND OF BUSINESS OR INDUSTRY Ship Repair		11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John W. Clary			14. MOTHER'S MAIDEN NAME Mary Annie ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-16-4160		17. INFORMANT Mary Clary		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 151X I			CAUSE OF DEATH (A) Gastric Cancer (B) gastric ulcer (C) _____			ADDRESS 934 Lemmon St. INTERVAL BETWEEN ONSET AND DEATH 6-8 mo 20 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. bronchopneumonia			2 weeks	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 1941 to July 1966 , that (I) (we) last saw the deceased alive on July 2, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE H. H. Baylus				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5 July 66	
23C. PHYSICIAN'S NAME (Type) H. H. BAYLUS				23D. ADDRESS 1600 WILKENS AVE 1			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/66		24C. NAME OF CEMETERY or CREMATORY London Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Ind.	
25A. DATE RECEIVED BY HEALTH DEPT. July 8 1966		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR John J. Cowan & Son, Inc.			
				ADDRESS 901 Hollins St. Balt 23 Ind.			



66 06795

BALTIMORE CITY HEALTH DEPARTMENT

66 06795

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)NATHAN
BENJAMIN GLICKSTEIN

2. DATE AND HOUR PRONOUNCED DEAD

3 July 1966 12:15 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

6980 Marsue Dr.

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 28, 1913

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MERCHANT

10B. KIND OF BUSINESS OR INDUSTRY

FURNITURE

11. BIRTHPLACE (State or foreign country)

CHELSEA MASS.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

MAX GLICKSTEIN

14. MOTHER'S MAIDEN NAME

GERTRUDE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

216-32-6455

17. INFORMANT

MRS. ROSE GLICKSTEIN, 6980 MARSUE DRIVE

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Madison St. at Broadway

21D. TIME OF INJURY
(APPROX.)

July 2, 1966 11:55 p.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ddriver in auto-auto-collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/3/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7/5/66

23C. NAME of CEMETERY or CREMATORY

HEBREW YOUNG MEN

23D. LOCATION

(City, town, or county)

BALTIMORE, MARYLAND

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 6 1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN

ADDRESS

WALSH & BROS.

NEW YORK, N.Y.

NEW YORK, N.Y.

NEW YORK, N.Y.

NEW YORK, N.Y.

FUNERAL DIRECTOR: IMPORTANT

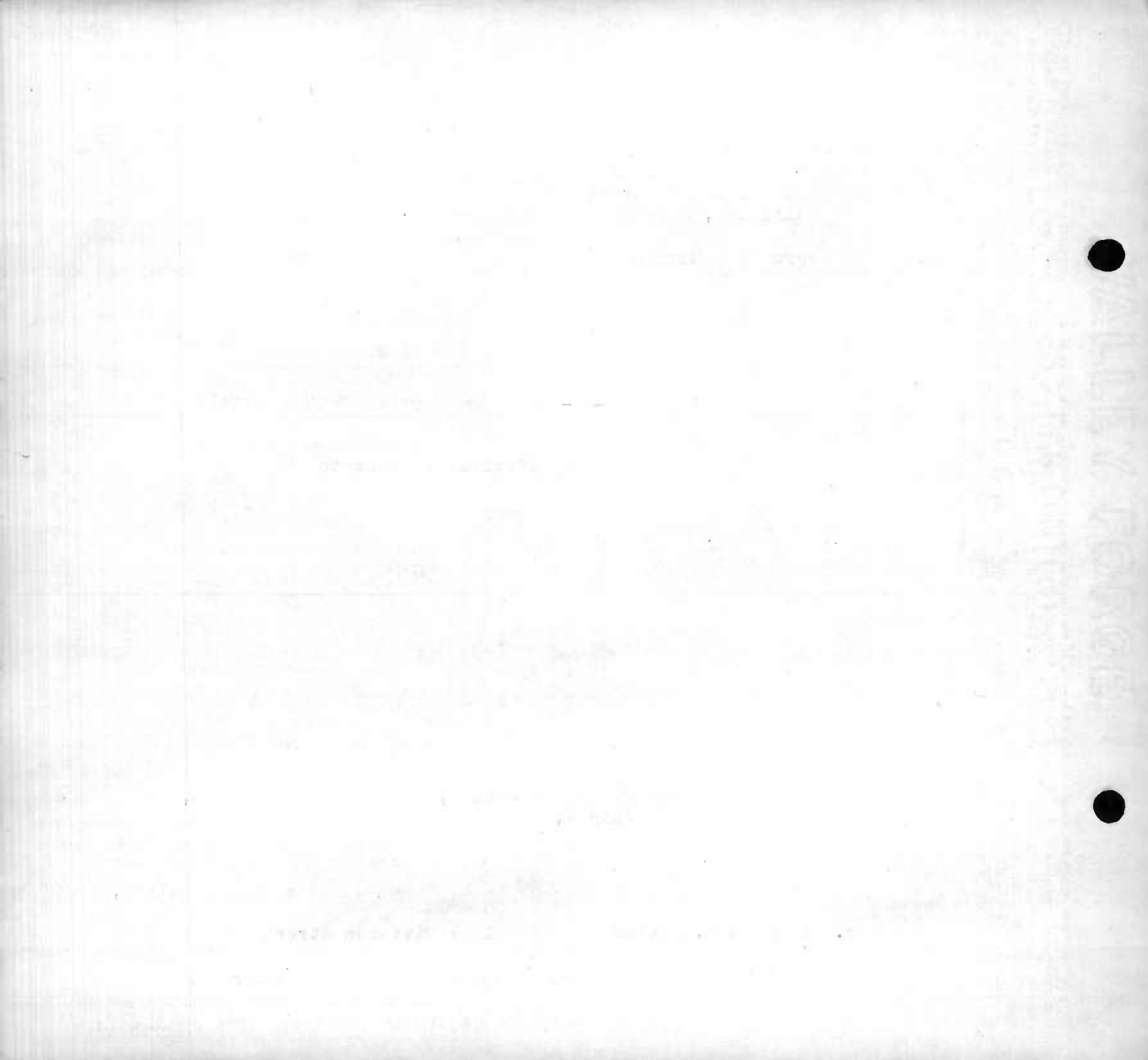
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06796				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06796	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				ANNA WESTRA		JULY 3, 1966 3:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
BOLTON HILL NURSING HOME				5208 CUTHBERT AVENUE MARYLAND			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
FEMALE		WHITE		WIDOWED			
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
NOV. 6, 1877		88		HOUSEWIFE		AT HOME	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
PATERSON, N.J.				U S A			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNKNOWN				UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						JACOB SCHLENGER 3616 CEDAR DRIVE #7	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				Arteriosclerotic Heart Disease		20 Years	
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Left Lower Lobe Pneumonia		1 Week	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from June 24 19 66 to July 3 19 66		that (I) (yes) last saw the deceased alive on July 2 19 66		and that in (my) (yes) opinion death occurred on the date and hour and from the causes stated above. (I) (yes) (did not) view the body after death.			
23A. SIGNATURE Stanley Z. Felsenberg				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED JULY 4, 1966	
23C. PHYSICIAN'S NAME (Print) STANLEY Z. FELSEBERG				23D. ADDRESS 3000 GLEN AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		7/5/66		LORRAINE PARK		BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 6 1966		Robert E. Felsberg		SOL LEVINSON & BROS		6010 REISTERSTOWN RD?	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06797		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06797	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Oscar Lee			2. DATE AND HOUR OF DEATH July 4, 1966 2:40 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division Street Baltimore, Maryland			A. STATE Maryland B. COUNTY 16-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3007 W. Lanvale Street		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/15/04	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pittsburg, Pa	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Emma Lee	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-12-9987		17. INFORMANT ADDRESS Mrs Jarvis 3007 W Lanvale St	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) I 177X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 6, 1966 to July 4, 1966 , that (I) (we) last saw the deceased alive on July 4, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Virgilio G. Javier			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 4, 1966
23C. PHYSICIAN'S NAME (Type) Dr. Virgilio G. Javier			23D. ADDRESS M.D. 1514 Division Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/9/66	24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Jarboe		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06798	
BIRTH NO. 66 06798		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Anna B. Marshall (Spencer)		2. DATE AND HOUR OF DEATH 7-2-66 7:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1703		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Bar-Wil-Ba Convalescent Home		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 716 Pierce St.	
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 9/5/02	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Mary Ruff 922 McDonough St	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) C.V.A. DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Recent broncho pneumonia					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-17-1966 to 7-2-1966 that (I) (we) last saw the deceased alive on 6-30-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C.R. Campbell		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-2-66	
23C. PHYSICIAN'S NAME (Type) C.R. Campbell		23D. ADDRESS M.D. 1618 W. North Ave. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/66		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR R. E. Taylor, M.D.	
25C. FUNERAL DIRECTOR H. Halstead		25D. ADDRESS 1206 W. Northham.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 06799					CERTIFICATE OF DEATH					Registered No. 66 06799									
1. NAME OF DECEASED (Type or Print) THOMAS FRAZZA FRAZZA										2. DATE AND HOUR OF DEATH 7-5-66 9:20 A.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSP.										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 23 S. ROBINSON ST.									
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH 5-02-06		9. AGE (In years last birthday) 60		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ANTHONY FRAZZA					14. MOTHER'S MAIDEN NAME ROSE PAPAGNA														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 5056					17. INFORMANT ADDRESS Mrs. Lida Frazza 23 S. Robinson St.									
18. I 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Myocardial Infarction Coronary Thrombosis										CAUSE OF DEATH Pulmonary edema Acute Myocardial Infarction Coronary Thrombosis					INTERVAL BETWEEN ONSET AND DEATH min min min				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 7-3-66 to 7-5-66 , that (I) (we) last saw the deceased alive on 7-5-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE [Signature]										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 7-5-66				
23C. PHYSICIAN'S NAME (Type) [Signature]										23D. ADDRESS [Signature]									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 7/8/66					24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.					24D. LOCATION (City, town, or county) (State) BALTO. MD.				
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966					25B. NAME OF REGISTRAR Robert E. Farley, M.D.					25C. FUNERAL DIRECTOR B. Dabrowski					ADDRESS 2818 E. BALTIMORE ST.				

ANTHONY FRASCA

Proctor &

M W M

1954 1954

1954

1954 1954

1954 1954

Italy

ROSE FABIANA

ANTHONY FRASCA

ANTHONY FRASCA

BIRTH NO. 65125408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)Craig Conway

2. DATE AND HOUR PRONOUNCED DEAD

7/5/66 3:54 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)39 Provident Hospital4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATEMaryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1805 Druid Hill Ave.

5. SEX

male

6. RACE

colored7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9-30-659. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.910A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md/12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Crystal Conway

14. MOTHER'S MAIDEN NAME

Phyliss Williams15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Phyliss Conway 1805 Druid Hill Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Interstitial pneumonitis (SDII)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?yes21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/5/6623A. BURIAL CREMATION,
REMOVAL (Specify)Burial

23B. DATE

7-7-66

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat'l. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 6 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Edo. Kelson

ADDRESS

1348 Calhoun St.

VALLEY FORCE

THE

1912

1913

1914

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1918

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1920

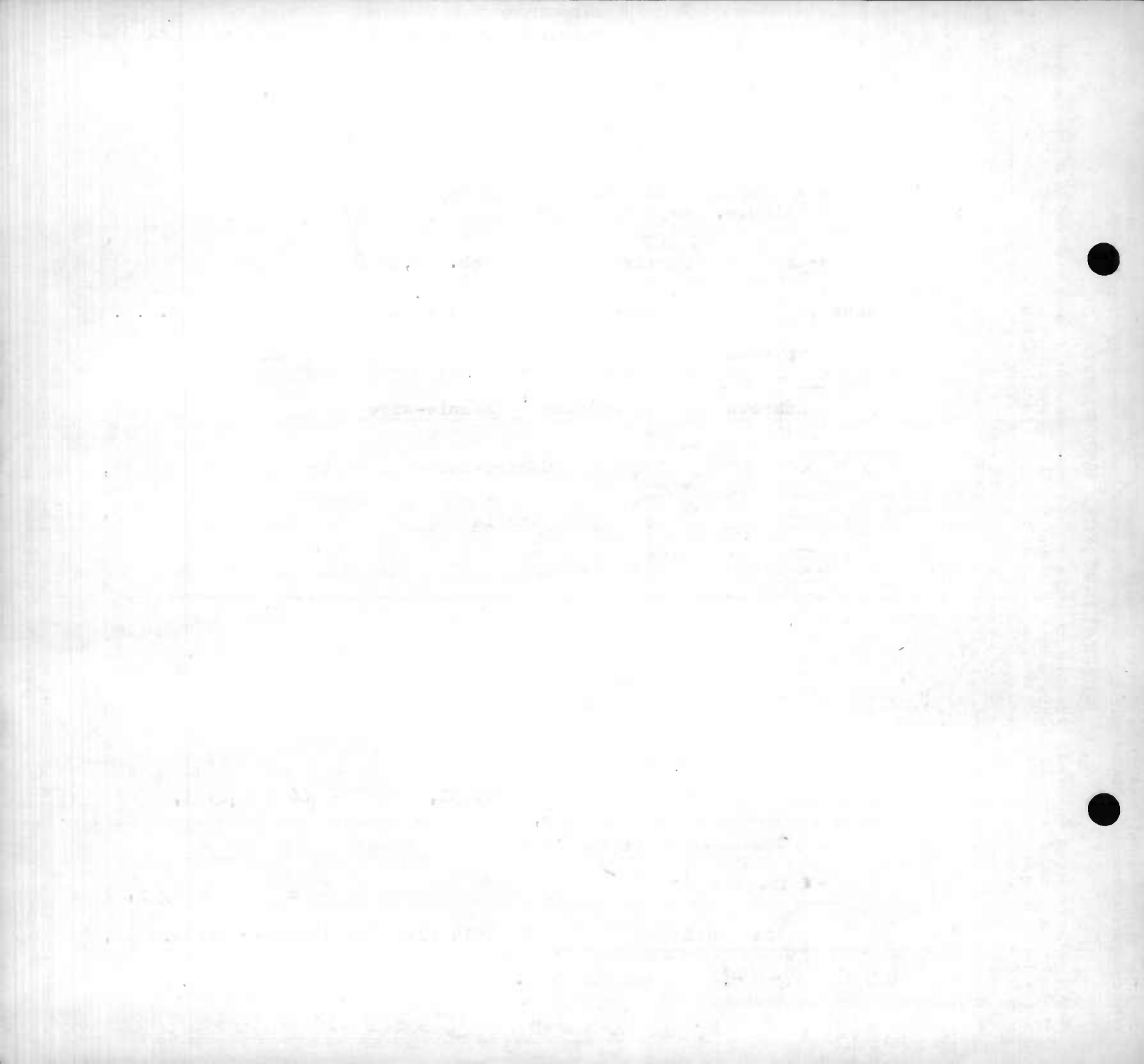
1921

1922

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06801				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06801	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Alonza Burnett				July 5, 1966 10:45a M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Provident Hospital 1514 Division Street Baltimore, Maryland 21217				Maryland Baltimore			
O. STREET ADDRESS (If rural, give location)				11-04			
1029 Tiffany Court							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Male	Negro	married	Feb. 25, 1896	70			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
none			none		Virginia		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
unknown				unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
unknown		unknown		Minnie-wife		same	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) Gastro-duodenal ulcer			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO			
ANTECEDENT CAUSES				(B) Anemia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO			
(C)				May 31, 1966 thru July 5, 1966			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0		none		none			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 31, 1966 to July 5, 1966, that (I) (we) last saw the deceased alive on July 5, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Ata Amini				July 5, 1966			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Ata Amini				M.D. 1514 Division Street-Baltimore 17, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-10-66		Church Cem.		Crew Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 6 1966		Robert E. Farley, M.D.		Geo. Keelson 1348		Alhoun St.	



FUNERAL DIRECTOR: IMPORTANT

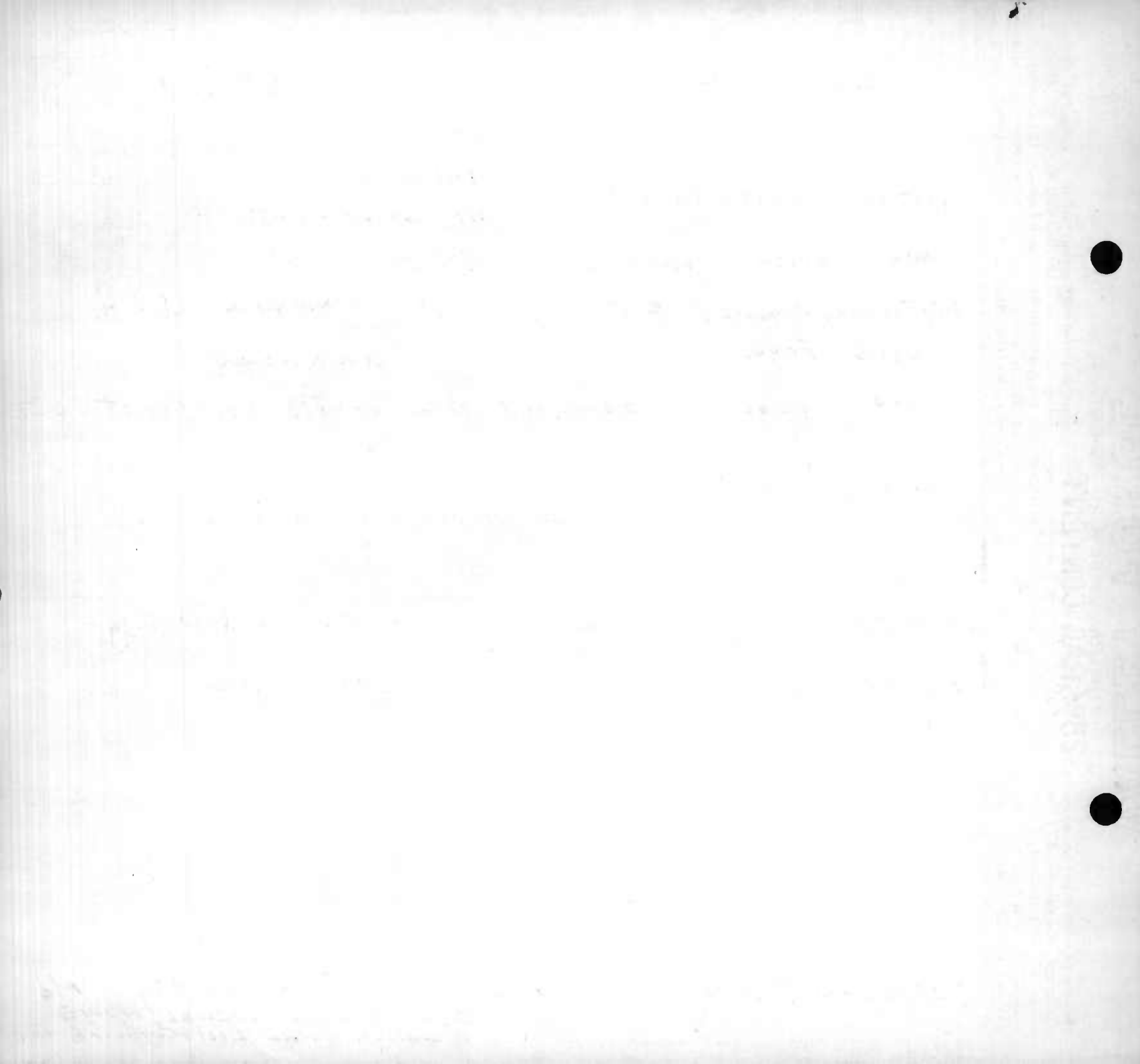
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06802		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06802	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ELEANOR FEFEL			2. DATE AND HOUR OF DEATH JULY 5 1966 12:55 a. m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MOUNT NURSING HOME 90 3706 NORTONIA ROAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 20-03 D. STREET ADDRESS (If rural, give location) 603 S. PAYSON ST.		
5. SEX FEMALE	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH Aug 25, 1896	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Tracey			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 21240-4369A		17. INFORMANT John FEFEL	
				ADDRESS 603 S. Payson St.	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease 6 years			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct. 26 1960 to July 5 1966 , that (I) was last saw the deceased alive on June 30, 1966 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death.					
23A. SIGNATURE Abraham B. Hurwitz				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ				23D. ADDRESS M.D. 7501 LIBERTY ROAD, BALTIMORE MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-8-66		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
				24D. LOCATION (City, town, or county) (State) Anne Arundel Cty. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS 650 E. Schuyler Ave. Francis H. Miller	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06803		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06803	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Louis F. Frye		2. DATE AND HOUR OF DEATH July 5th 1966 5:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bow Secours Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 20-03 D. STREET ADDRESS (If rural, give location) 117 Christian St. 21223			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 7-8-90	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATIONARY ENGINEER Print Htg.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Louis Frye		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 213-09-9857		17. INFORMANT ADDRESS Katherine Frye 1917 Christian St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4-22-11		CAUSE OF DEATH (A) DUE TO Congestive heart failure (B) DUE TO Arterio-scler. cardiovascular disease (C)		INTERVAL BETWEEN ONSET AND DEATH months years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II		Bronchogenic carcinoma, (Rt) lung			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/15 19 66 to 7/5 19 66 , that (I) (we) last saw the deceased alive on 2 PM 7/5 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 7/5/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-9-66		24C. NAME OF CEMETERY or CREMATORY cedar HILL	
24D. LOCATION (City, town, or county) (State) Anne Arundel Cty md.		25C. FUNERAL DIRECTOR ADDRESS Geo. L. Schwab Funeral Home Francis X. Miller 2101 Rudwick Ave			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Farley M.D.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

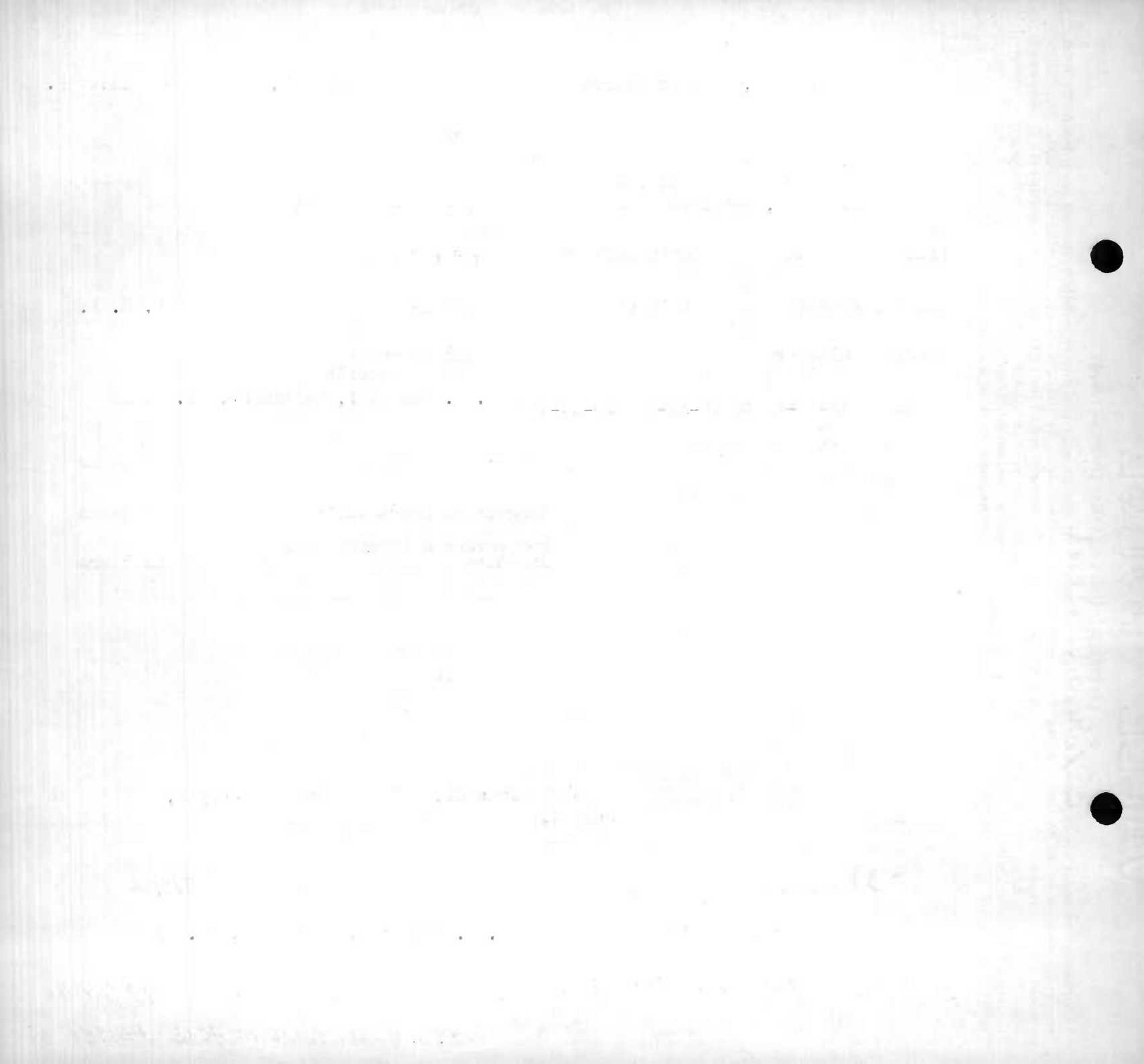
BIRTH NO. 66 06804		HEALTH DEPARTMENT		Registered No. 66 06804	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) THEODORE N. HARTMAN			2. DATE AND HOUR OF DEATH JULY 5, 1966 12:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO, MD. EMROSE BOARDING HOME.		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 331 ST PAUL PLACE BALTO., MD.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 14-01		
D. STREET ADDRESS (If rural, give location) 1803 EUTAW PLACE					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 4-25-97	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN LABORER		10B. KIND OF BUSINESS OR INDUSTRY Cemetery		11. BIRTHPLACE (State or foreign country) BALTO. CITY	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME CHARLES HARTMAN			
14. MOTHER'S MAIDEN NAME MARIA MELSEHEFSKI		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No NONE			
16. SOCIAL SECURITY NO. 218-09-8235		17. INFORMANT PATIENT.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarct			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Emphysema			(B) Generalized Arteriosclerosis		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-29 19 66 to 2-5 19 66 , that (I) (we) last saw the deceased alive on 7-5-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. M. Barash M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 7-5-66	
23C. PHYSICIAN'S NAME (Type) J. M. BARASH M.D.				23D. ADDRESS MERCY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-8-66		24C. NAME of CEMETERY or CREMATORY Louisa PARK	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR GEORGE L. Schwab FUNERAL HOME Francis H. Miller 2101 Frederick Ave			

Best Myrmecophilus
Bambusa

Myrmecophilus

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

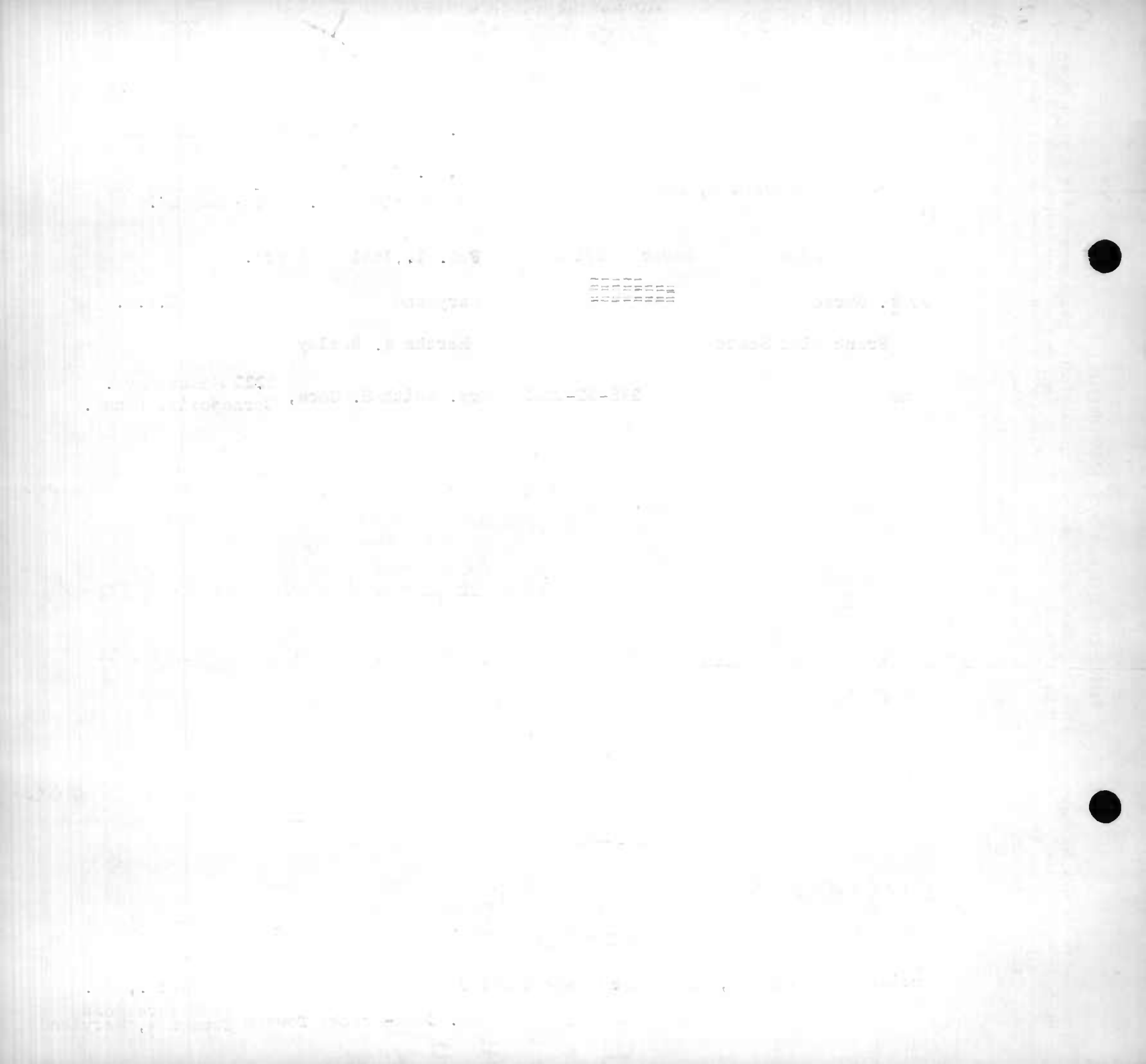
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06805	
66 06805			CERTIFICATE OF DEATH		
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) WHITENER, Chester Alfred			July 4, 1966 11:00 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			A. STATE Maryland B. COUNTY Baltimore		
27			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 2-61		
			D. STREET ADDRESS (If rural, give location) 2030 Gough Street		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 6-6-1922	9. AGE (In years lost birthday) 44	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lathe Operator		10B. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Charles Whitener			14. MOTHER'S MAIDEN NAME Tillie Rulka		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11-21-42 to 10-14-45		16. SOCIAL SECURITY NO. 213-16-5995	17. INFORMANT Records ADDRESS V. A. Hospital, Baltimore, Md. 21218		
18. 00-2-2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiration failure INTERVAL BETWEEN ONSET AND DEATH 2 Weeks					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Congestive Heart Failure 2 Years					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Far Advanced Tuberculosis Inactive 12 Years					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (X) (this hospital) attended the deceased from June 21, 1966 to July 4, 1966 , that (X) (we) last saw the deceased alive on July 4, 1966 and that in (X) (my) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas Zizic			23B. DATE SIGNED 7/5/66		
23C. PHYSICIAN'S NAME (Type) Thomas Zizic			23D. ADDRESS V. A. Hospital, Baltimore, Md. 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7-8-1966	24C. NAME of CEMETERY or CREMATORY HOLY ROSARY CEM.	24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	25C. FUNERAL DIRECTOR ADDRESS JOHN M. WEBER & SONS INC. 401 S. CHESTER ST.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 06806				
BIRTH NO. 66 06806					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Martha Scott					2. DATE AND HOUR OF DEATH 7/2/66 9:30 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Midtown Home, Inc					A. STATE Md. B. COUNTY Baltimore				
CITY OR TOWN (If outside city limits, write RURAL and give township) Rt. 1. Timonium					D. STREET ADDRESS (If rural, give location) Greenspring Ave. & Broadway Rd.				
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH Feb. 10, 1881	9. AGE (In years lost birthday) 85 yrs.	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pract. Nurse			10B. KIND OF BUSINESS OR INDUSTRY =====		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank Gist Scott					14. MOTHER'S MAIDEN NAME Martha R. Bosley				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 218-32-0203		17. INFORMANT ADDRESS Mrs. Edith S. Gore, 1222 McCave Ave. Coraopolis, Penna.				
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardio Respiratory Failure					Massive Cerebral Vascular Thrombosis				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Gen. Arteriosclerotic					Gen. Hypertrophic Arthritis (non-rod)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Sept 1 1963 to July 2 1966 , that (I) (we) last saw the deceased alive on July 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE William D. Appleford					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) William D. Appleford					23D. ADDRESS 5907 Park Heights N.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 6, 1966		24C. NAME OF CEMETERY or CREMATORY Black Rock Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 4, Maryland					



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66 06807

BALTIMORE CITY HEALTH DEPARTMENT

66 06807 ✓

BIRTH NO. 62-14735 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		Susan Shimanek		2. DATE AND HOUR PRONOUNCED DEAD 7/5/66 7:45 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home and Hospital				A. STATE Maryland	
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-03	
				D. STREET ADDRESS (If rural, give location) 104 N. Bradford St.	
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH June 9, 1962	9. AGE (In years lost birthday) 4
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME James Shimanek				14. MOTHER'S MAIDEN NAME Anna Ruth Sheeks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Anna Ruth Vavilis 104 N. Bradford St. #24	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
				(A) Traumatic concussion DUE TO	
				(B) DUE TO	
				(C) DUE TO	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 104 Bradford St. 6-03	
21D. TIME OF INJURY (APPROX.) 7 4 66 ?		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell down steps	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7/7/66		23C. NAME OF CEMETERY or CREMATORY Prospect Hill Cemetery	
24A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		24B. NAME OF REGISTRAR Robert E. Farber		24C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202	
				24D. LOCATION (City, town, or county) (State) Towson, Maryland 21204	

VALLEY FORDS

HAB. CONTENT

USA

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[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

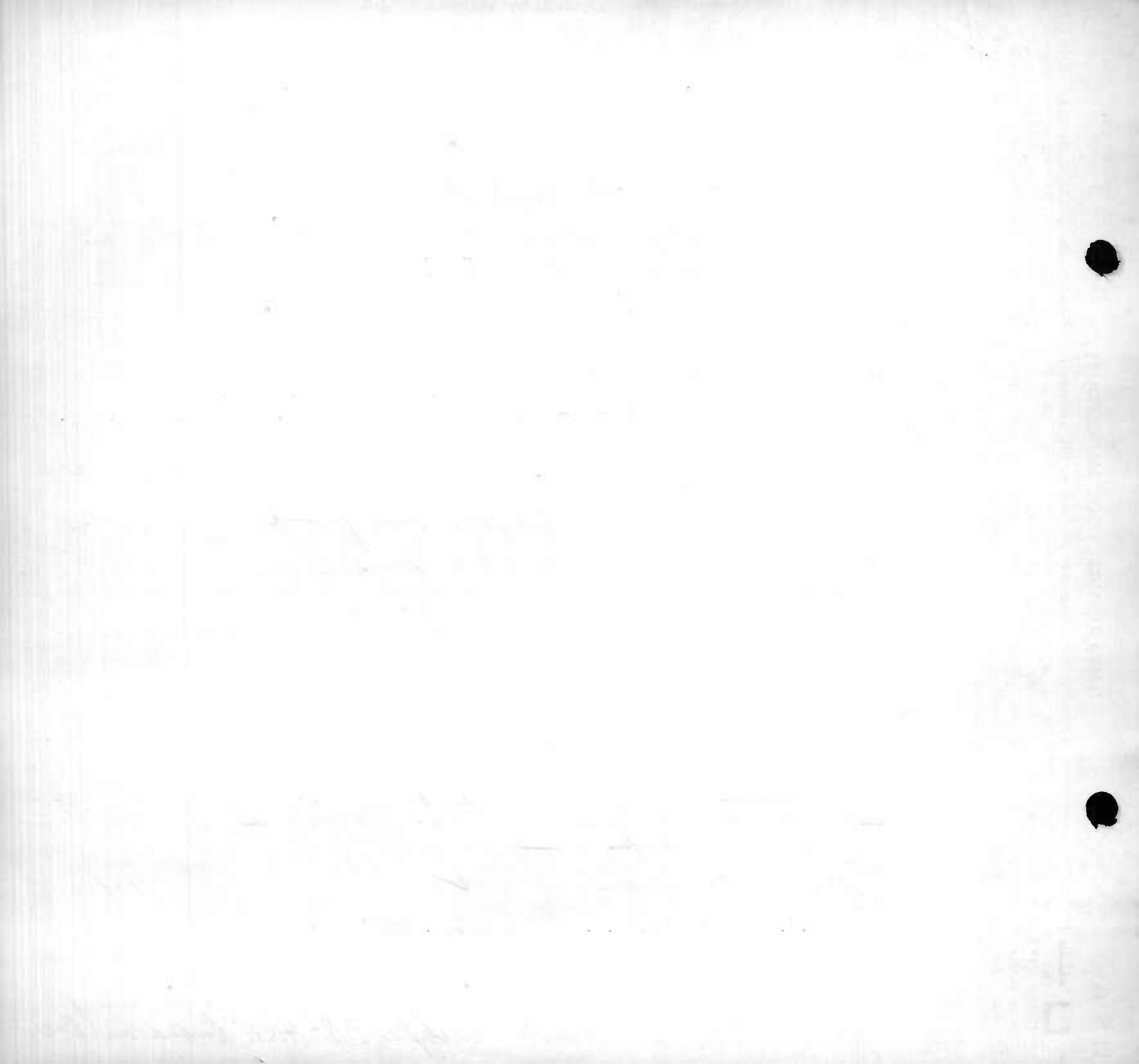
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06808</u>	
BIRTH NO. <u>66 06808</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Henry L. Jones</u>		2. DATE AND HOUR OF DEATH <u>July 4, 1966</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY _____			
FULL NAME OF HOSPITAL OR INSTITUTION <u>3214 Leeds St.</u> <u>00</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3214 Leeds St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Wh</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>May 1, 1904</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Baker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry J. Jones (late)</u>		14. MOTHER'S MAIDEN NAME <u>Barbara M. Miller (late)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>217-05-6626</u>		17. INFORMANT ADDRESS <u>Mr. Louis Jones 3214 Leeds St.</u>	
18. <u>4221 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>atherosclerosis</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 1950</u> to <u>July 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>July 4, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J.C. Pound</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7/6/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>J.C. Pound</u>		23D. ADDRESS <u>3325 Fredrick av</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-7-66</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. DATE REC'D BY HEALTH DEPT.			
25A. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25B. FUNERAL DIRECTOR <u>WITZKE</u>		25C. ADDRESS <u>4101 Edmondson Ave.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 06809	
BIRTH NO. 66 06809		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Helen A. Bower		2. DATE AND HOUR OF DEATH July 4, 1966 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY	
4630 Rokeyby Road		Baltimore, 29, Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 28-04	
D. STREET ADDRESS (If rural, give location)		4630 Rokeyby Rd.		E. CITY OR TOWN		F. COUNTY	
5. SEX F	6. RACE Wh	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 3-31-83	9. AGE (in years last birthday) 83	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)
Seamstress		Dept. store		Sharpsburg, Md.		USA	
13. FATHER'S NAME Seaman				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-05-6362		17. INFORMANT Mr. Chester F. Bower		ADDRESS 4630 Rokeyby Rd., Balto., 29, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
ACUTE PULMONARY EDEMA		1/2 hour					
CONGESTIVE HEART FAILURE		2 months					
A.S.C.V. DISEASE							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Sensitivity					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 1, 1966 to July 4, 1966, that (I) (we) last saw the deceased alive on June 30, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE D.C. MacLaughlin, M.D.		23B. DATE SIGNED 7/5/66			
23C. PHYSICIAN'S NAME (Type) D.C. MacLaughlin, M.D.		23D. ADDRESS 303 N. Rolling Road					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-66		24C. NAME of CEMETERY or CREMATORY Rest Haven Cem.		24D. LOCATION (City, town, or county) (State) Hagerstown, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR A. E. E. F. F. F.		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

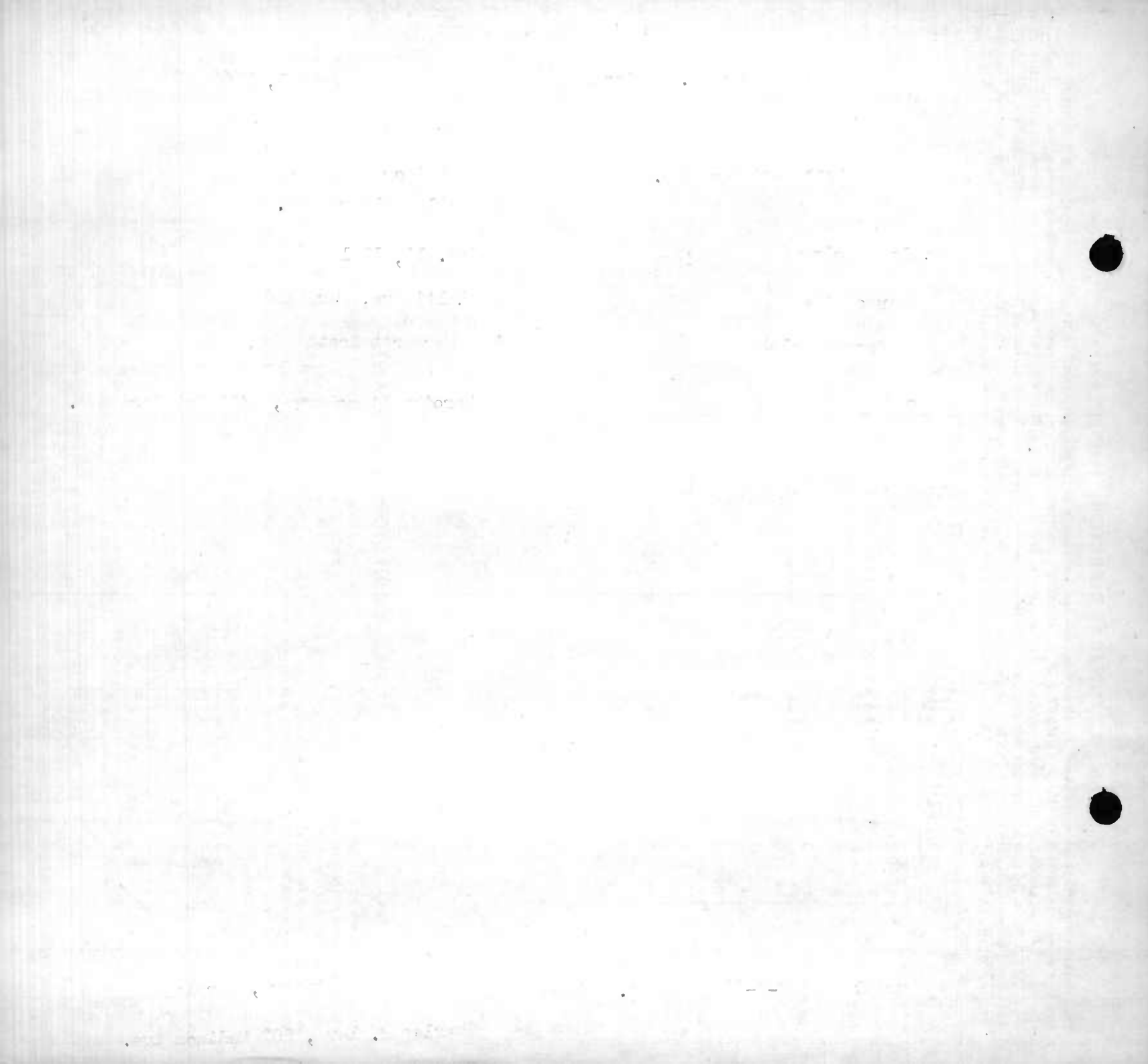
BIRTH NO. 66 06810				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06810	
1. NAME OF DECEASED (Type or Print) Marie A. Hilgeman				2. DATE AND HOUR OF DEATH July 5, 1966 5 ⁰⁸ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Hillvale Road Baltimore, 29, Md.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 48 Hillvale Rd.			
5. SEX F	6. RACE Wh	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-26-15	9. AGE (In years last birthday) 50	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10B. KIND OF BUSINESS OR INDUSTRY Dept. store		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Blahut				14. MOTHER'S MAIDEN NAME Late Mary Kmach			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-38-5542		17. INFORMANT Mr. George K. Hilgeman		ADDRESS 29, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Cerebral Neoplasm (B) DUE TO Metastatic from a primary (C) Great malignancy		INTERVAL BETWEEN ONSET AND DEATH 2-3 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1966 to July 5, 1966, that (I) (we) lost saw the deceased alive on July 1, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Edgar Williamson, M.D.				23B. DATE SIGNED July 6-66			
23C. PHYSICIAN'S NAME (Type) Edgar Williamson, M.D.				23D. ADDRESS PROFESSIONAL ARTS BUILDING 5550 BALTIMORE NATIONAL PIKE BALTIMORE 28, MARYLAND			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7-8-66		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR A. E. E. Farber		25C. FUNERAL DIRECTOR W. F. A. - 4101 Concord Ave.		ADDRESS	

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 58TH STREET
CHICAGO, ILL. 60637

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

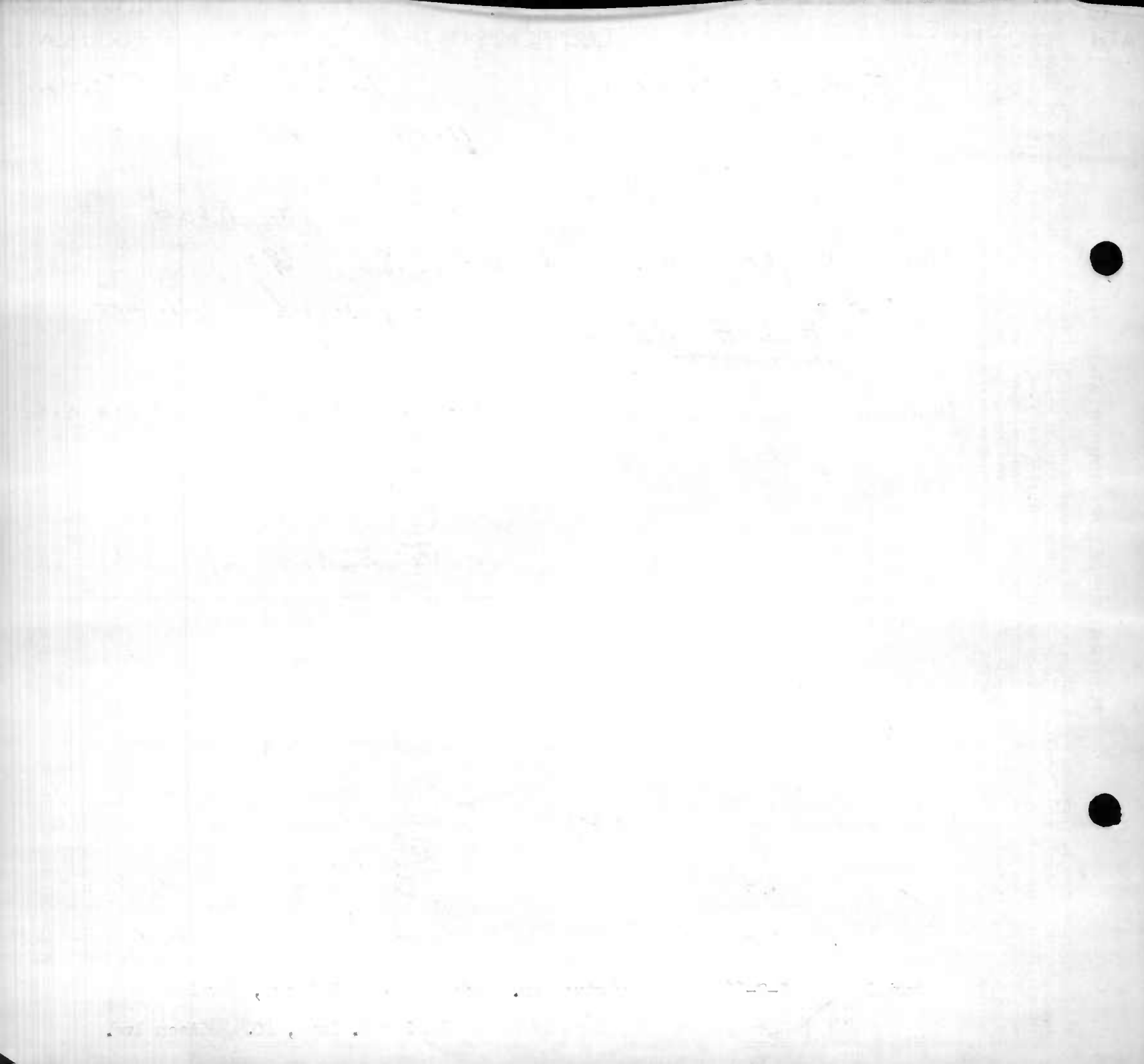
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06811</u>	
BIRTH NO. <u>66 06811</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mary E. Addison</u>		2. DATE AND HOUR OF DEATH <u>July 1, 1966</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____			
FULL NAME OF HOSPITAL OR INSTITUTION <u>2411 Guilford Ave.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>2411 Guilford Ave.</u>			
5. SEX <u>Female</u>	6. RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct. 13, 1901</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>George Welsh</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Scott</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dorothy Stansbury, 2411 Guilford Ave.</u>	
18. <u>430.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u>		CAUSE OF DEATH (A) DUE TO <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <u>Pyelonephritis</u>		<u>3 days.</u>	
(C) <u>Arteriosclerosis</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Anemia</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>December 19 63</u> to <u>July 1 19 66</u> , that (I) (we) last saw the deceased alive on <u>July 1 19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jesse T. Holmes</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>July 5, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jesse T. Holmes</u>		23D. ADDRESS <u>508 E North Ave. BALT. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-5-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1966</u>		24F. NAME OF REGISTRAR <u>Robert E. Farley</u>	
24G. FUNERAL DIRECTOR <u>Charles R. Law</u>		24H. ADDRESS <u>802 Madison Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06812		CERTIFICATE OF DEATH		Registered No. 66 06812	
1. NAME OF DECEASED (Type or Print) Estelle Flournoy				2. DATE AND HOUR OF DEATH 7-4-1966 9:00 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) George Washington 90 CARVER Nurs. Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk D. STREET ADDRESS (If rural, give location) 210 Sellers Pt. Road					
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH SEPT. 18 1896		9. AGE (In years lost birthday) 69?		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME ALLIE HALL Unknown				14. MOTHER'S MARDEN NAME ALICE HALL					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO.		17. INFORMANT CHART # 783 607 Penna Ave				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Myocardial Infarction (A) Coronary Occlusion - acute DUE TO		INTERVAL BETWEEN ONSET AND DEATH 17			
				(B) Hypertensive card-vasc. Dis DUE TO		Unknown			
(C) Chronic Glomerulonephritis		Unknown							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that it (this hospital) attended the deceased from April 8 19 66 to July 4 19 66 , that it (we) last saw the deceased alive on July 4 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E.E. Holt				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/4/66			
23C. PHYSICIAN'S NAME (Type) E.E. Holt				23D. ADDRESS M.D. 3715 Liberty (Hydr. Ave. Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-66		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Farley, MA		25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS , 802 Madison Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06813		BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH		Registered No. 66 06813	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GREEN, BLANCHE R.		2. DATE AND HOUR OF DEATH 1 Jul 66 530 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 33-09	
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		D. STREET ADDRESS (If rural, give location) 145 Siegmund Lane		SIEGMUND	
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) D.V.	8. DATE OF BIRTH 5/19/27	9. AGE (In years last birthday) 39	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter Williams		14. MOTHER'S MAIDEN NAME Nannie Mithers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Nannie Francis	
ADDRESS		522 N. Lenoir St.			
18. 194 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Tracheal compression DUE TO (B) Hemorrhage DUE TO (C) On Duroid + Radical Neck Dissection			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6-7-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED On Duroid		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-15-66 19 to 7-1-66 19, that (I) (we) last saw the deceased alive on 7-1-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE T.G. Dodenhoff		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1 Jul 66	
23C. PHYSICIAN'S NAME (Type) T.G. DODENHOFF		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-66		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR The Charles R. Law 802 Madison Ave.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06814				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06814	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Jeannette Johnson</i>				2. DATE AND HOUR OF DEATH <i>7/5/66 900 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Franklin Square Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 19-01</i>			
				D. STREET ADDRESS (If rural, give location) <i>1429 W. Franklin St</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>7/11/01</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>STEEL Phil Sheppard</i>				14. MOTHER'S MAIDEN NAME <i>HESTER Steel</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT <i>Hospital Record</i>		ADDRESS	
18. <i>340.31</i> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Acute Purulent Meningitis</i>				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7/2</i> 19 <i>66</i> to <i>7/5</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>7/5</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>RAYMUNDO S. MAGNO</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/6/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>RAYMUNDO S. MAGNO</i>				23D. ADDRESS <i>Franklin Square Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-9-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Carver Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Laurel, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 6 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Charles R. Law, 802 Madison Ave.</i>			

1
M-200

66 06815

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 06815

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Isabella Mackay

2. DATE AND HOUR PRONOUNCED DEAD

7/4/66 10:30 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3314 Elgin Ave.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Feb. 20, 1888

9. AGE (in years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Mitchell

14. MOTHER'S MAIDEN NAME

Helen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-32-5961

17. INFORMANT

ADDRESS

Mrs. Virginia Bigby, 3314 Elgin St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic cardiovascular disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/5/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-8-66

23C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 6 1966

Robert E. Farley, M.D.

Charles R. Law, 802 Madison Ave.

VALLEY

FUNERAL DIRECTOR: IMPORTANT

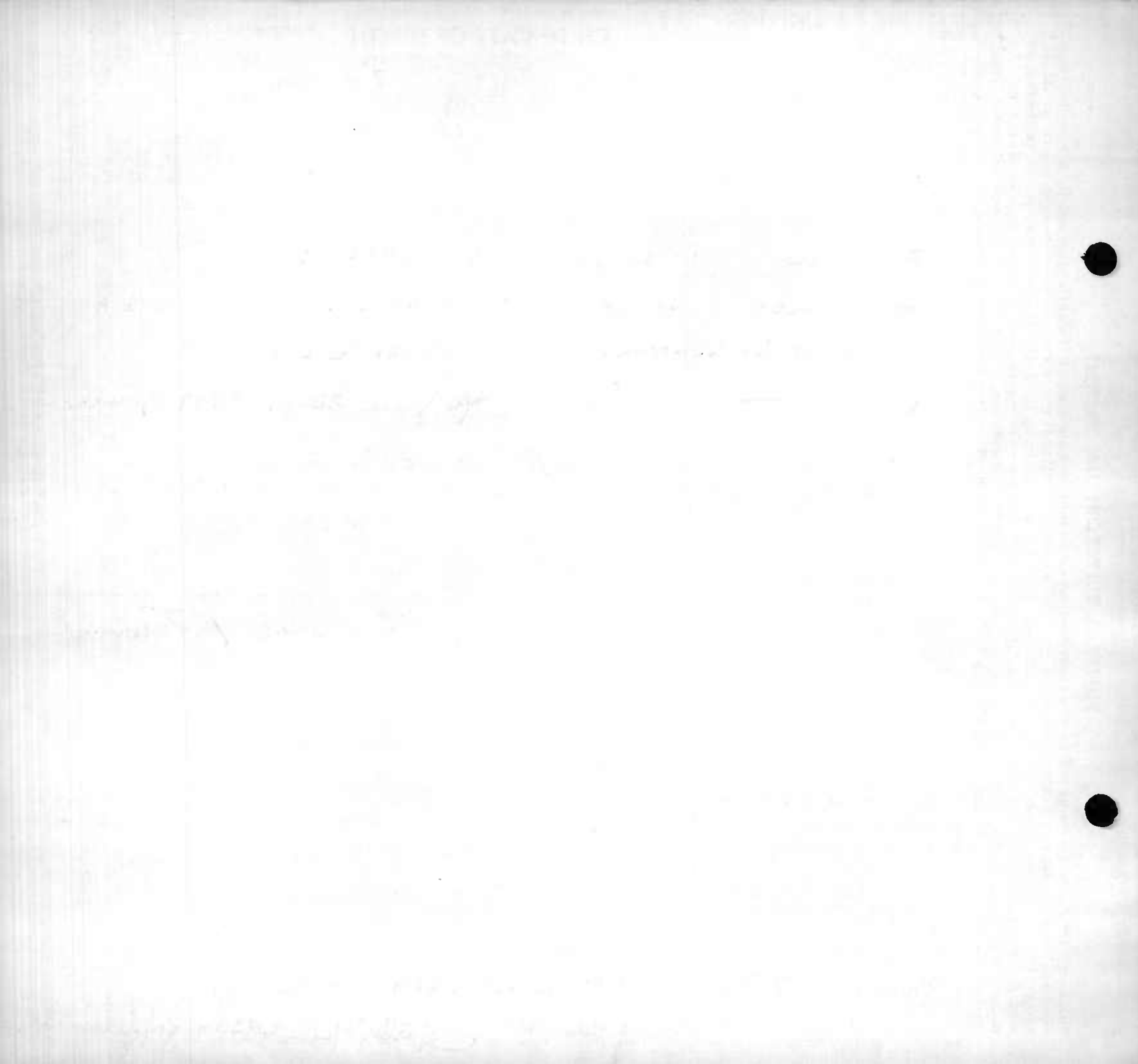
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06816</u>	
BIRTH NO. <u>66 06816</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mary Gransee</u>		2. DATE AND HOUR OF DEATH <u>7-2-66</u> <u>8:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>FAYETTE CONV. HOME</u>		A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>5-01</u> D. STREET ADDRESS (If rural, give location) <u>1105 E. FAYETTE ST.</u>			
5. SEX <u>7</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>9/24/1863</u>	9. AGE (In years lost birthday) <u>102</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>450.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Generalized arteriosclerosis</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Osteoarthritis</u>		<u>Several yrs</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-4-1959</u> to <u>7-2-1966</u> , that (I) (we) last saw the deceased alive on <u>6-30-1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Ellsworth Cook</u>				23B. DATE SIGNED <u>7-2-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook</u>				23D. ADDRESS M.D. <u>2431 Md. Ave. Balto. Md. 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>July 5 '66</u>		24C. NAME OF CEMETERY or CREMATORY <u>ZION EVANGELICAL</u>	
24D. LOCATION (City, town, or county) (State) <u>GOLDEN RING RD - ENNEP MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>WITZKE - 4101 EDMONDSON AVE</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
66 06817					CERTIFICATE OF DEATH		Registered No. 66 06817			
BIRTH NO. M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) MARY L. FORT					
2. DATE AND HOUR OF DEATH 7-4-1966					M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MIDTOWN NURSING HOME					A. STATE MARYLAND					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-03					
					D. STREET ADDRESS (If rural, give location) 3227 RAMONA AVE.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9-1-1882	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER			10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE L. LOHMANN					14. MOTHER'S MAIDEN NAME MARY DIEST					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS Mrs. Julia Stenzel - 3227 Ramona Ave.					
18. 4428 I CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH ?					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) Anterior Acute Cardiac Vascular renal disease					
ANTECEDENT CAUSES					(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Bronchial Pneumonia					
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/28 19 64 to 7/4 19 66 , that (I) (we) last saw the deceased alive on 2/10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Joseph S. Blum M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 7/5/66		
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM M.D.					23D. ADDRESS 1154 CALVERT ST.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-7-66		24C. NAME OF CEMETERY or CREMATORY TRINITY LUTHERAN CEM.			24D. LOCATION (City, town, or county) (State) BALTO. MD.			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966			25B. NAME OF REGISTRAR Robert E. Farkner			25C. FUNERAL DIRECTOR ADDRESS Harley J. Allen - 2334 Jefferson St.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06818	
<div> <div>66 06818</div> <div>(SOPHIE)</div> </div> <div>CERTIFICATE OF DEATH</div>					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				SOPHIE SMITH	
2. DATE AND HOUR OF DEATH		74-66 445 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 10 BOLTON HILL NURSING HOME LAFAYETTE & JOHN ST.			A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3314 KENYON AVE.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W	WIDOWED	7-30-1878	84	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOMEMAKER		HOME		MARYLAND.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
EDWARD CERNICK			ANNA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Mrs. Annie Hodges - 3314 Kenyon Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			cerebro-vascular accident		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			thrombosis		
			(B) DUE TO		
			arteriosclerosis		
			(C) DUE TO		
			several yrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Dec. 1965 to 7-4-1966, that (I) (we) last saw the deceased alive on 7-3-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
E. Ellsworth Cook				7-5-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
E. ELLSWORTH COOK				2431 MARYLAND AVE. BALTO 21218 MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		7-7-66		OAK LAWN CEM.	
				BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 6 1966		Robert E. Farkema		2334 JEFFERSON ST. Stanley Apple	

FOR SALE & LEASE
Gordon & Son's

2-20-1812 81
2-20-1812 81

Myers

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Myers & Son

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1

66 06819

BALTIMORE CITY HEALTH DEPARTMENT

66 06819

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Elvin A. Study, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

7/5/66

3:20 a.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

1625 Gough St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1625 Gough St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

1-28-03

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CUSTODIAN

10B. KIND OF BUSINESS OR INDUSTRY

CITY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

IRA STUDY

14. MOTHER'S MAIDEN NAME

SADIE BRICKA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

176-05-3900

17. INFORMANT

ADDRESS

Mrs. Christina G. Study - 1625 Gough St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Active pulmonary tuberculosis

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/5/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7-9-66

23C. NAME OF CEMETERY or CREMATORY

BALTIMORE CEM.

23D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

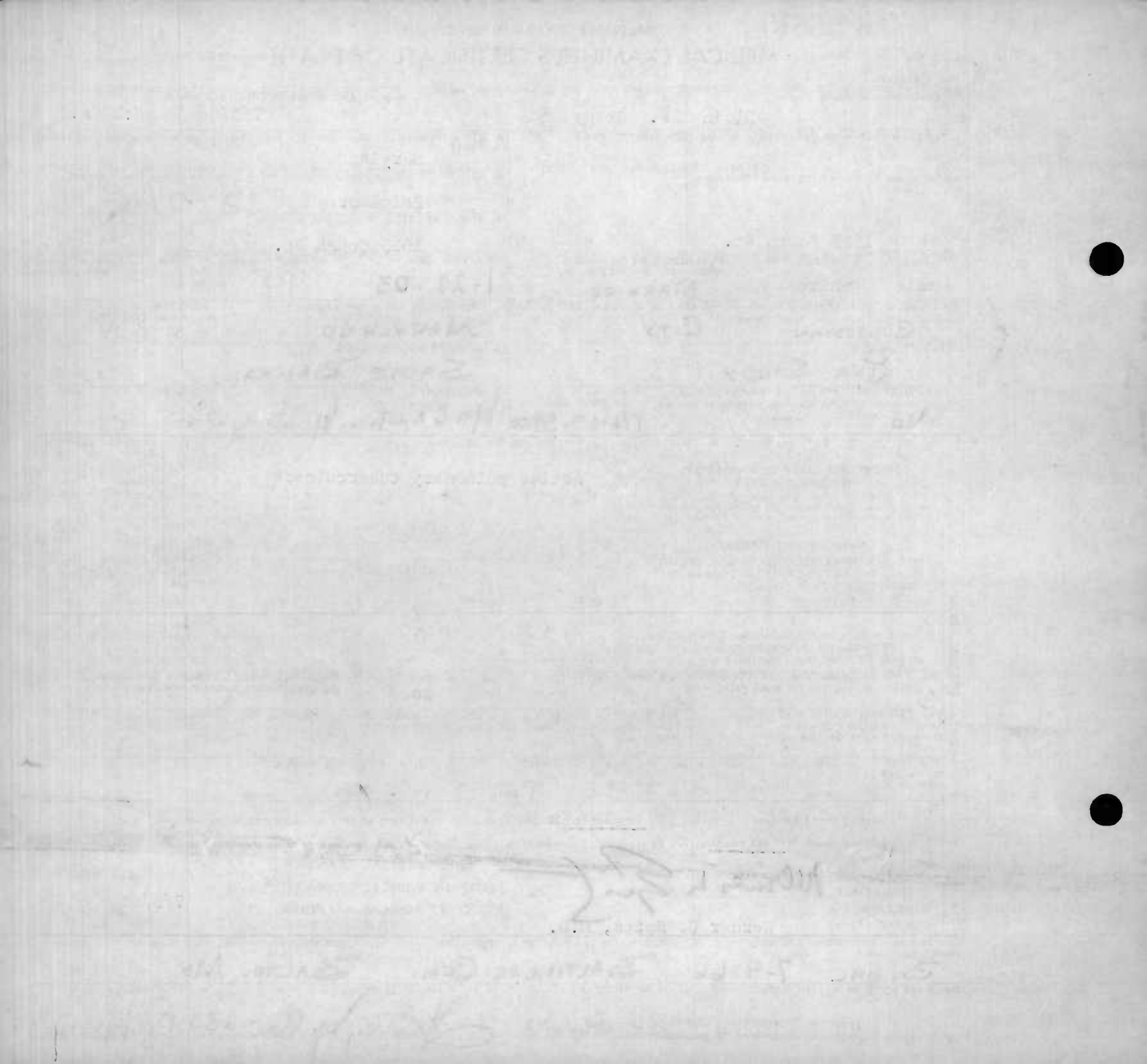
24C. FUNERAL DIRECTOR

ADDRESS

JUL 6 1966

Robert E. Farkas, M.D.

Hartley, Spitz - 2334 Jefferson St.



66 06820

BALTIMORE CITY HEALTH DEPARTMENT

66 06820

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE R. HAWORTH

2. DATE AND HOUR PRONOUNCED DEAD

2 July 1966

5:40 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

300 Broadmoor Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

300 Broadmoor Rd.

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

June 25, 1888

9. AGE (in years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired - Vice President

10B. KIND OF BUSINESS OR INDUSTRY

W. M.
R. R.

11. BIRTHPLACE (State or foreign country)

Phillipsburg, Pa.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Richard L. Haworth

14. MOTHER'S MAIDEN NAME

Rose Bloom

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Herbert F. Kuenne 1214 Munsey Bldg.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

300 Broadmoor Rd.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
July 2, 1966 5:25 p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot self in head

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/3/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/6/1966

23C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

23D. LOCATION

(City, town, or county)

(State)

Woodlawn, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 6 1966

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Wm. J. Fickner & Sons Baltimore, Md.

ADDRESS

WALTER E. FOSTER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06821		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06821	
1. NAME OF DECEASED (Type or Print) Taylor O. Wardin				2. DATE AND HOUR OF DEATH July 4, 1966 5 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midtown Nursing Home 808 Saint Paul Street Baltimore, Maryland 21202				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 1929 Saint Paul Street							
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH May 29, 1895	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant - Retired			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John O. Wardin				14. MOTHER'S MAIDEN NAME Mary Taylor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None			16. SOCIAL SECURITY NO. 216-05-7501		17. INFORMANT ADDRESS Miss Christine Purnell 2014 St. Paul St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cardio-Respiratory Failure Engelbrecht Heart Failure (B) Hypertensive - art. C.V.D. Central thrombosis, old (C) Diabetes Mellitus Hemiplegia, (R) old		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 23 1957 to July 4 1966 that (I) (we) last saw the deceased alive on July 4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE William Appleberry M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED 7/6/66	
23C. PHYSICIAN'S NAME (Type) William Appleberry M.D.						23D. ADDRESS 5501 Park Heights Dr.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/1966		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966		25B. NAME OF REGISTRAR Robert E. Farber, MA		25C. FUNERAL DIRECTOR Wm. J. Fickner + Sons		ADDRESS Baltimore, Md. North Ave.	

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66 06822

BALTIMORE CITY HEALTH DEPARTMENT

66 06822

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) John Dotson				2. DATE AND HOUR PRONOUNCED DEAD 7/4/66 11:40 p. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1515 E. Lafayette Ave.							
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Sep.	8. DATE OF BIRTH 10-21-1926	9. AGE (In years last birthday) 39	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO. Md.						
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Andrew Dotson			14. MOTHER'S MAIDEN NAME Gladney					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII.			16. SOCIAL SECURITY NO. 212-20-7557			17. INFORMANT Mrs. Gertrude Brown			ADDRESS 3702 Edgewood		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 204.1 Chronic myelogenous leukemia				(A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO							
(C) DUE TO											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) no			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 7/5/66					
M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>								
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			23B. DATE 7-8-66			23C. NAME OF CEMETERY or CREMATORY BALTO. NAT'L C.			23D. LOCATION (City, town, or county) (State) BALTO., Md.		
24A. DATE REC'D BY HEALTH DEPT. JUL 6 1966			24B. NAME OF REGISTRAR W. J. Spitz			24C. FUNERAL DIRECTOR MORTON & Dyett			ADDRESS 1701		

RECEIVED

VALLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06823	
BIRTH NO. 66 06823		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MINNIE JEFFERSON		2. DATE AND HOUR OF DEATH 7-2-66 12³⁰ P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lincoln Memorial Nursing Home 2701 Carey St.		A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1118 ETTING ST.	
5. SEX F	6. RACE Negro	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12-25-1895
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 81
11. BIRTHPLACE (State or foreign country) UNK.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNK.		14. MOTHER'S MAIDEN NAME UNK.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. UNK.	
17. INFORMANT Minnie Little John		ADDRESS 2701 Carey St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 493X I CAUSE OF DEATH PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 3 days.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) - NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/29/62 19 to 7/2/66 19, that (I) (we) last saw the deceased alive on 7/2/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature]		23B. DATE SIGNED 7/5/66	
23C. PHYSICIAN'S NAME (Type) HOLLIS STEINARINE M.D.		23D. ADDRESS 2519 KENNISON AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-66	
24C. NAME OF CEMETERY or CREMATORY MT CALVARY		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Jackson	
25C. FUNERAL DIRECTOR Morton - Wright		ADDRESS	

2-2

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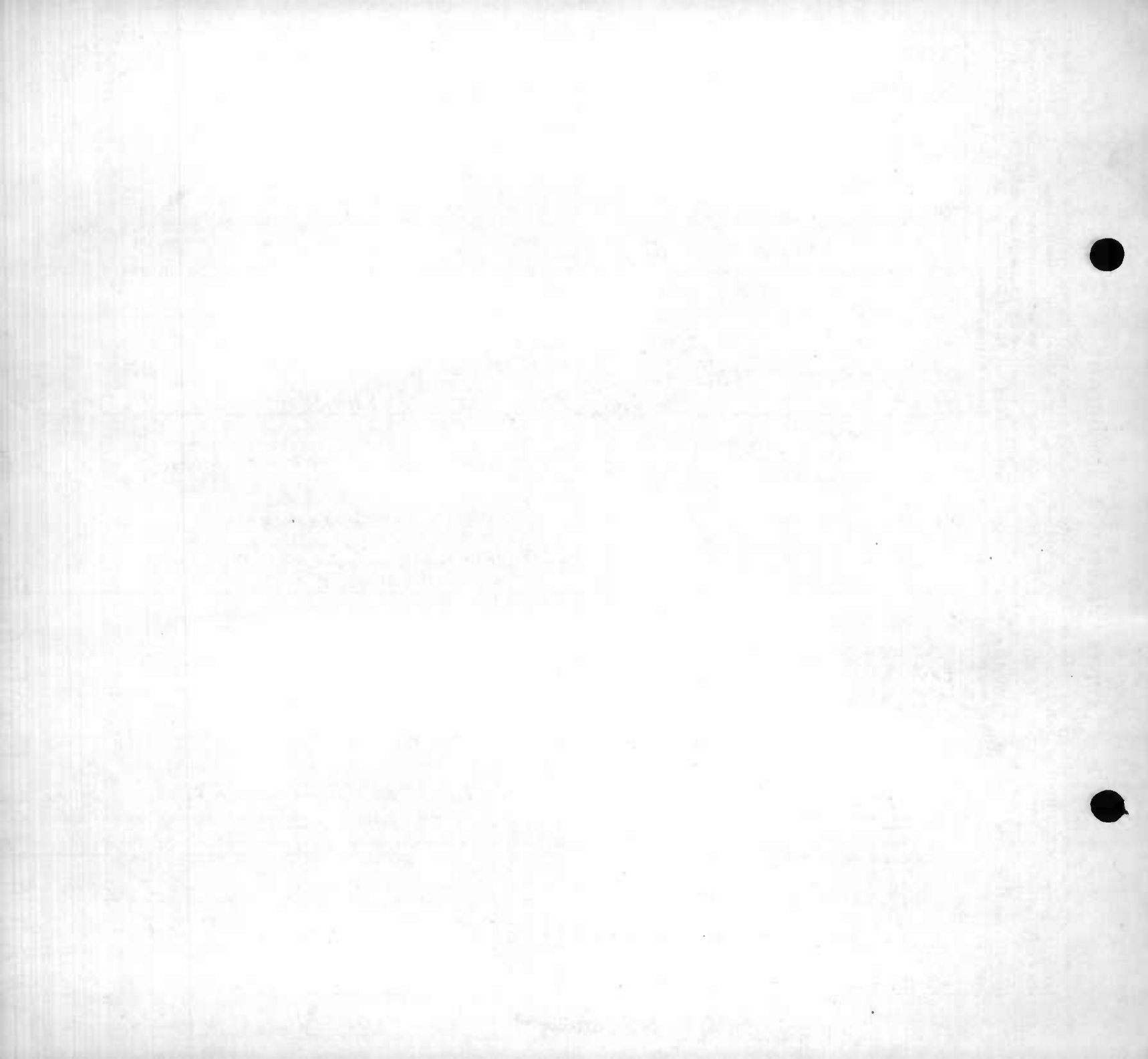
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 06824		CERTIFICATE OF DEATH		66 06824	
1. NAME OF DECEASED (Type or Print) CLEO B. HARRIS			2. DATE AND HOUR OF DEATH 7-5-66 10⁴⁰ AM. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN Hospital of Md.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-48 D. STREET ADDRESS (If rural, give location) 777 Grantly		
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH OCT. 30 - 1914	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME John Bailey			14. MOTHER'S MAIDEN NAME unk.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 216-24-5067	17. INFORMANT Mr. George Harris ADDRESS 1624 ABBOTSON ST.		
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) acute ecchymia + intercurrent infection DUE TO (B) Terminal Carcinomatosis DUE TO (C) CARCINOMA, Anaplastic + Cervix-invasive INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 5-13-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-12 19 66 to 7-5 19 66 , that (I) (we) last saw the deceased alive on 7-5 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Mamaril Jr. M.D.				23B. DATE SIGNED 7-5-66	
23C. PHYSICIAN'S NAME (Type) ANSELMO MAMARIL, Jr. M.D.		23D. ADDRESS Lutheran Hospital of Md.			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7-9-66	24C. NAME OF CEMETERY or CREMATORY Arbutus Mem.	24D. LOCATION (City, town, or county) (State) Arbutus Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR Robert E. Fickens	25C. FUNERAL DIRECTOR MORTON + Dye ADDRESS 1701 Laurens			



1
C-200

66 06825

BALTIMORE CITY HEALTH DEPARTMENT

66 06825

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

NELLIE CHASE

2. DATE AND HOUR PRONOUNCED DEAD

2 July 1966

7:05 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1510 Caroline St.

5. SEX

female

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Aug. 26 1900

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

York Lancaster Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lew Roberta Baker 1510 N. Caroline

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic
DUE TO cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Charles S. Petty
Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/2/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WALLACE JOSE

1
C-200

BALTIMORE CITY HEALTH DEPARTMENT

66 06826

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY L.

COOK

(Cooke)

2. DATE AND HOUR PRONOUNCED DEAD

July 3, 1966

12:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 12-03

D. STREET ADDRESS (If rural, give location)

2425 Barclay Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

April 5, 1934

9. AGE (In years
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Nurse Assistant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign, country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Richard Cook

14. MOTHER'S MAIDEN NAME

Chamnie Penderexter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lottie Cook 2425 Barclay St

18.

174 X₁

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of uterus with widespread
metastases

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 4, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

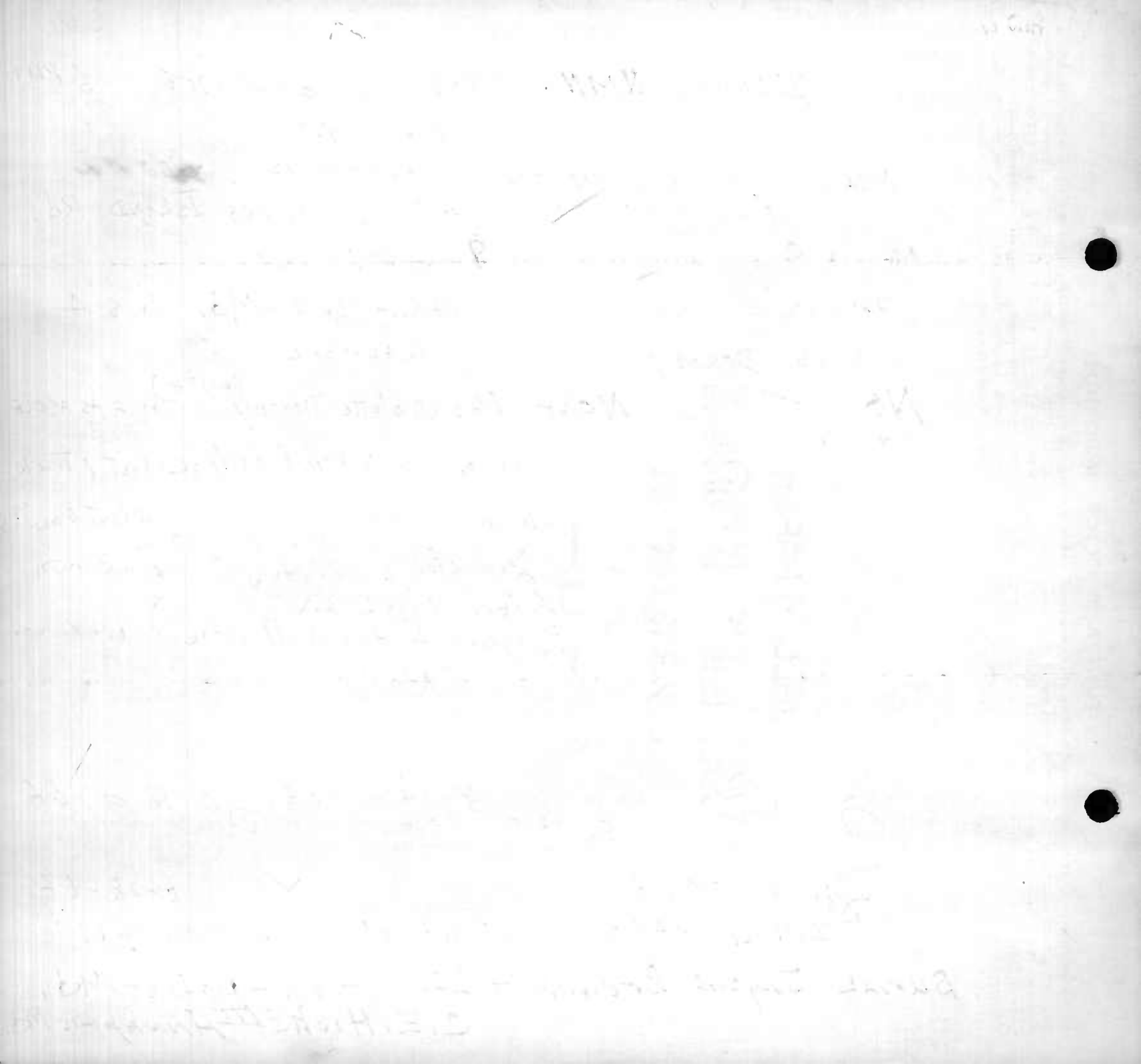
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 06827	
BIRTH NO. 66 06827		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lee Elmer Jenkins				2. DATE AND HOUR OF DEATH 7/3/66				6:40 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION Century Home. Inc						A. STATE Maryland B. COUNTY Baltimore					
(If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
						D. STREET ADDRESS Irwin Way Drive					
5. SEX male		6. RACE white		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 3/17/90		9. AGE (In years last birthday) 76		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Front Royal, Virginia				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Jenkins						14. MOTHER'S MAIDEN NAME Emma Robinson					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Norman Jenkins				ADDRESS Hagerstown, Md. 11 Madison Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
						(A) Cardio-Respiratory Failure Coronary Heart Failure (B) Anteroseptal CVD Amputation Leg (R) (C) Epilepsy					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
						20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 7 1964 to July 3 1966 , that (I) (we) last saw the deceased alive on July 3 1966 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
23A. SIGNATURE William D Applever D						23B. DATE SIGNED 7/4/66					
23C. PHYSICIAN'S NAME (Type) William D Applever D						23D. ADDRESS 5501 Park Heights Dr					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/66		24C. NAME OF CEMETERY or CREMATORY Rest Haven Cemetery				24D. LOCATION (City, town, or county) (State) Hagerstown Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966				25B. NAME OF REGISTRAR Robert E. Farley, M.D.				25C. FUNERAL DIRECTOR W. G. Horst ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.			

Wm C. Hunt

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06828		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06828	
1. NAME OF DECEASED (Type or Print) DORSEY NMN. ROBERT			2. DATE AND HOUR OF DEATH 6-28-1966 6 PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL BALTIMORE, M.D.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY AA C. CITY OR TOWN (If outside city limits, write RURAL and give township) ANNAPOLIS 52-10 D. STREET ADDRESS (If rural, give location) 45, SOLOMONS ISLAND Rd.		
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-26-1897	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			11. BIRTHPLACE (State or foreign country) ANNAPOLIS - Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES DORSEY			14. MOTHER'S MAIDEN NAME RACHAEL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE	17. INFORMANT (WIFE) ADDRESS Mrs Violette Dorsey SAME AS ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHRONIC KIDNEY FAILURE			19. CAUSE OF DEATH (A) DUE TO CHRONIC KIDNEY FAILURE (B) DUE TO CHRONIC PYELONEPHRITIS & KIDNEY STONE (C) DUE TO DIABETES MELLITUS		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIABETES MELLITUS			21. INTERVAL BETWEEN ONSET AND DEATH about 4 months		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Liver cirrhosis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-24-1966 to 6-28-1966 that (I) (we) last saw the deceased alive on 6-28-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Zin U. Park				23B. DATE SIGNED 6-28-66	
23C. PHYSICIAN'S NAME (Type) ZIN U. PARK				23D. ADDRESS Montebello state Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE July 2-66		24C. NAME of CEMETERY or CREMATORY Brewer Hill	
24D. LOCATION (City, town, or county) (State) ANNAPOLIS - Md.		25A. DATE REC'D JUL 6 1966			
25B. NAME OF REGISTRAR Robert E. Stanley, M.D.		25C. FUNERAL DIRECTOR ADDRESS C. E. Hicks III ANNAPOLIS MD.			



Released by Medical Examiner R. B. B. 5-10-66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06829		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06829	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>Pearlene Spriggs</i>		2. DATE AND HOUR OF DEATH <i>7/1/66 17th A. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 13-03</i> D. STREET ADDRESS (If rural, give location) <i>2434 Madison Ave</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital</i> <i>42</i>					
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Divorced</i>	8. DATE OF BIRTH <i>11/22/41</i>	9. AGE (In years lost birthday) <i>24</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
13. FATHER'S NAME <i>PAUL E. HAYNESWORTH, Sr</i>		14. MOTHER'S MAIDEN NAME <i>Pearl Reaves</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-38-0366</i>		17. INFORMANT <i>PAUL E. HAYNESWORTH, Sr - 69 John Hanover</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>II</i>		CAUSE OF DEATH <i>? Anoxic Hard Embolism</i>		ADDRESS <i>Frederick, Md</i> INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Deceased Normally at 5:35 AM</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert M. Blum</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/1/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert M. Blum</i>		23D. ADDRESS <i>Sinai Hospital Baltimore, Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-5-1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Fairview</i>	
24D. LOCATION (City, town, or county) (State) <i>Frederick Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>7-5-1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taney</i>		25C. FUNERAL DIRECTOR <i>C.F. HICKS</i>			
		ADDRESS <i>Frederick, Md</i>			

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2001 BY 60322 UCBAW/STP

SECRETARY OF DEFENSE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 66 06830	
BIRTH NO. 66 06830				CERTIFICATE OF DEATH			
M.E. CASE NO.				DATE AND HOUR OF DEATH 7-4-66 4:00 P M.			
1. NAME OF DECEASED (Type or Print) Blanche I. Heim				2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Bolton Hill Nursing Home				A. STATE Md B. COUNTY A.A. Co			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Severna Park			
D. STREET ADDRESS (If rural, give location) 401 Riggs Av							
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 4-29-25	9. AGE (in years last birthday) 41	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife @ home	11. BIRTHPLACE (State or foreign country) Baltimore Md	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. [redacted]		17. INFORMANT ADDRESS Joseph Tramer - Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) cerebro-vascular accident DUE TO generalized arteriosclerosis (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH one day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-9-66 19 to 7-4-66 19, that (I) (we) last saw the deceased alive on 7-4 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE E. Ellsworth Cook				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-4-66	
23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK				23D. ADDRESS 2431 Maryland Ave. Balto 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-6-66		24C. NAME of CEMETERY or CREMATORY Parkwood Cem		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Joseph S. Saranaco		ADDRESS Severna Park Md	

10/1/19

10/1/19



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06831	
BIRTH NO. 66 06831		DATE AND HOUR OF DEATH 7-4-66 9:15 A.M.	
M.E. CASE NO. ARTAOR VICE		1. NAME OF DECEASED (Type or Print) ARTAOR VICE	
CERTIFICATE AMENDED		2. DATE AND HOUR OF DEATH 7-4-66 9:15 A.M.	
3. PLACE OF DEATH (In Baltimore, Maryland, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) 40 Baltimore 53-00	
5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 2-14-02 9. AGE (in years last birthday) 64 63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad LABORER		11. BIRTHPLACE (State or foreign country) Italy	
10B. KIND OF BUSINESS OR INDUSTRY Railroad		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN VICE		14. MOTHER'S MAIDEN NAME MARY D'AMBROSIO	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 717-07-6326	
17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Ave., Balto, Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 502.11		CAUSE OF DEATH Hypoxia, pulm. embolus	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		INTERVAL BETWEEN ONSET AND DEATH 20 years	
(A) Chronic Bronchitis		40 years	
(B) Extreme obesity		2 days	
(C) Pneumonia			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive heart failure - mild			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 7/3 1966 to 7/4 1966 and that (I) (we) last saw the deceased alive on 7/4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Franklin G. Strauss M.D.		23B. DATE SIGNED 7/4/66	
23C. PHYSICIAN'S NAME (Type) FRANKLIN G. STRAUSS M.D.		23D. ADDRESS 4940 Eastern Avenue, Balto. Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/7/66	
24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR ULLRICH FUNERAL HOME - DUNDALK MD		ADDRESS	

Letter from BCH (Josephine Wright RRL) 7/13/66 re change in date of birth

1
S-552

66 06832

BALTIMORE CITY HEALTH DEPARTMENT

66 06832

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWIN J. SIMMONS

2. DATE AND HOUR PRONOUNCED DEAD

July 1, 1966 11:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

John Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Pennsylvania

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Lebanon

D. STREET ADDRESS (If rural, give location)

713 State Drive

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

Aug. 7, 1945

9. AGE (In years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Soldier

10B. KIND OF BUSINESS OR INDUSTRY

U S Army

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward D. Simmons

14. MOTHER'S MAIDEN NAME

Kathryn Zeigler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

10-24-65/ 1966

16. SOCIAL
SECURITY NO.

203-36-2975 File No. 201

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple injuries
DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Road

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

East of Goldon Ring Road

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
July 1, 1966 1:08

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Passenger in auto - tree collision

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 1, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-6-1966

23C. NAME of CEMETERY or CREMATORY

Arlington National Cem

23D. LOCATION

(City, town, or county)

Arlington, Va.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 7 1966

Robert E. Fawcett, M.D.

Lee A. Paterson & Sons, Baltimore Md

WALLACE POLICE

PAGE 10 ITEM 10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06833</u>	
BIRTH NO. <u>66 06833</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED <u>C. HARLES REASIN</u>		2. DATE AND HOUR OF DEATH <u>6/30/66</u> <u>7:06</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Md. GEN'L Hosp</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>Hanover</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>HANOVER & GRACE</u>			
		D. STREET ADDRESS (If rural, give location) <u>553 CONGRESS AVE</u> <u>62-24</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7/12/99</u>	9. AGE (in years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ALFRED R REASIN</u>		14. MOTHER'S MAIDEN NAME <u>TOWNSEND</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW.I</u>		16. SOCIAL SECURITY NO. <u>218-03-2166</u>		17. INFORMANT <u>L.O. OSEN, MD - Md. GEN'L Hosp</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO <u>Myocardial Infarction</u>		<u>2 days</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <u>Arteriosclerotic heart disease</u>		<u>> 3 mos.</u>	
II		(C) -----			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>6/28</u> 19 <u>66</u> to <u>6/30</u> 19 <u>66</u> , that (I) last saw the deceased alive on <u>6/30</u> 19 <u>66</u> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louis O. Osen</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/30/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Louis O. Osen</u>		23D. ADDRESS <u>Md. General Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 3, 1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Angel Hill Cemetery</u>	
24D. LOCATION (City, town or county) (State) <u>Hanover & Grace Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farber, MA</u>		25C. FUNERAL DIRECTOR <u>Lee M. Patterson & Son, Perryville, Md</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06834		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 766 06834	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Jasper Jordan		2. DATE AND HOUR OF DEATH 7/5/66 11:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		B. COUNTY Baltimore	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland		D. STREET ADDRESS (If rural, give location)		423 E. 20th St. #21218	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/20/08	9. AGE (In years lost birthday) 58	10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY Hod Carrier		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ben		14. MOTHER'S MAIDEN NAME Barbara Howard		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT #21224		ADDRESS RECORDS-BCH-4940 Eastern Avenue	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Respiratory failure insufficient Bronchogenic Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 6 wks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		unknown	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/21/66 19 to 7/5/66 19 that (I) (we) last saw the deceased alive on 7/5/66 19 and that in (my) (our) opinion death occurred on the date and hour not from the causes stated above (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE William Emerson		23B. DATE SIGNED 7/5/66	
23C. PHYSICIAN'S NAME (Type) Dr. William Emerson		23D. ADDRESS BCH-4940 Eastern Avenue, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-66		24C. NAME of CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR 1735 Harford Ave. Marshall W. Jones, Jr.		25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06835	
BIRTH NO. 66 06835		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH July 4, 1966 3:05 P.M.	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) William H. Fields		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3104 Auchentoroly Terrace			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-22-1910	9. AGE (In years lost birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motor Sales Buick		10B. KIND OF BUSINESS OR INDUSTRY Motor Sales Buick		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John Robert Fields		14. MOTHER'S MAIDEN NAME Mamie Corbin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 3-01-3954		17. INFORMANT ADDRESS 3104 Auchentoroly Ter. Mrs. Esther Fields	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEAT STROKE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HCV.D.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 12 hours 3 yrs.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3104 Auchentoroly Terrace	
21D. TIME OF INJURY (APPROX.) July 4, 1966 ?		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? High Environmental temperature	
22. I certify that (I) (this hospital) attended the deceased from July 4, 1966 to July 4, 1966, that (I) (we) lost saw the deceased alive on July 4, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Percival C. Smith				23B. DATE SIGNED July 4, 1966	
23C. PHYSICIAN'S NAME (Type) Dr. Percival C. Smith				23D. ADDRESS 1514 Division Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-66		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966			
25B. NAME OF REGISTRAR A. E. Jones		25C. FUNERAL DIRECTOR 1735 Harford Ave. Marshall W. Jones, Jr.			

15-10-1950

1000 1000 1000
1000 1000 1000

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06836	
BIRTH NO. 66 06836		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Samuel N. Jackson		2. DATE AND HOUR OF DEATH 7/6/66 4:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital Baltimore, Maryland		A. STATE Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 414 E. Lanvale Street			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-30-04	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Samuel Jackson			14. MOTHER'S MAIDEN NAME Maud Matthews		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Viola Smith 414 E. Lanvale St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Severe Toxemia		CAUSE OF DEATH (A) DUE TO Severe Toxemia		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pneumonia & pleurisy		(B) DUE TO Pneumonia & pleurisy		2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) Malnutrition, CVA			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/5/66 19 66 to 7/6 19 66 , that (I) (we) last saw the deceased alive on 7/6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. M. Magno				23B. DATE SIGNED 7/6/66	
23C. PHYSICIAN'S NAME (Type) Raymundo S. Magno		23D. ADDRESS Franklin Square Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-1966		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR 1735 Harford Ave. Marshall W. Jones, Jr.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> R-1521 66 06837 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> BIRTH NO. Registered No. 66 06837 </div>			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Zora May Robinson</u>		2. DATE AND HOUR OF DEATH <u>July 5, 1966</u> <u>1</u> <u>4:10</u> <u>P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>44 Union Memorial Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12</u> <u>02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>311 E. 31st St.</u>	
5. SEX <u>F</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>7-15-88</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Butter-Egg</u>	9. AGE (In years last birthday) <u>77</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joshua Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Fannie E. Slade</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-6351</u>	17. INFORMANT <u>Mrs. Robert Manuel</u>
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CVA</u>		ADDRESS <u>Hogkins Apts.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Parkinsonism</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u>	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 25</u> <u>1966</u> to <u>July 5</u> <u>1966</u> , that (I) (we) lost saw the deceased alive on <u>June 5</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Miriam L. Cohen</u>		23B. DATE SIGNED <u>7-5-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>MIRIAM L. COHEN</u>		23D. ADDRESS <u>Towson, Maryland</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/8/1966</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Seitz Funeral Home</u>		24D. LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u>	
25C. FUNERAL DIRECTOR <u>Eugenia K. Seitz</u>		ADDRESS <u>Seitz Funeral Home Balto. Md.</u>	

CVA

General ASCVD

~~_____~~

For K. Brown

W

2012-12-12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

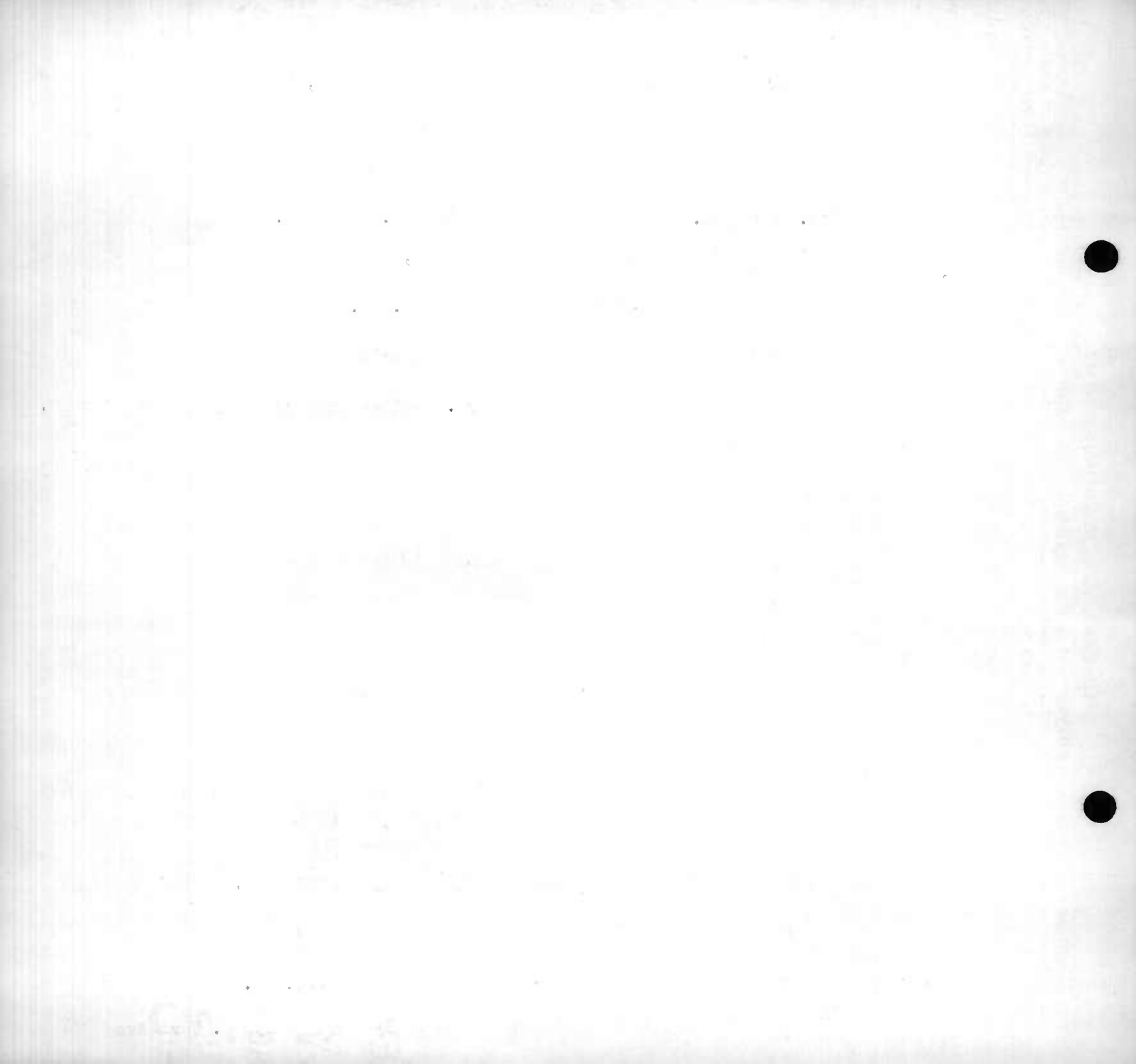
BIRTH NO. 66 06838		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06838	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JAMES F. DRISCOLL			2. DATE AND HOUR OF DEATH 6-29-66 5:45 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 28 S. Highland Ave. 00			A. STATE Md. B. COUNTY 26-10		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Highlandtown			D. STREET ADDRESS (If rural, give location) 28 S. Highland Ave. (24)		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/1/01	9. AGE (In years last birthday) 64	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James F. Driscoll			14. MOTHER'S MAIDEN NAME Minnie Steinkam		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Wife (Same as above)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 162.1 I Metastatic Carcinoma of Spine DUE TO Primary Carcinoma of Lung DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-31-1966 to 6-29-66 1966 that (I) (we) last saw the deceased alive on 6-29-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Costantini				23B. DATE SIGNED 7-1-66	
23C. PHYSICIAN'S NAME (Type) JOHN COSTANTINI				23D. ADDRESS 234 S. CONKLING ST. BALTO. 24 MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/66		24C. NAME OF CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION (City, town, or county) (State) Balto. Co. Md.		25A. DATE RECEIVED BY HEALTH DEPT. JUL 7 1966			
25B. NAME OF REGISTRAR Robert E. Starnes, MA		25C. FUNERAL DIRECTOR ADDRESS Connelly Sons 300 Mace Ave. 24			

WILLIAM H. HARRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06839		REGISTERED NO. 66 06839	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Mary Gebhart		July 4, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland B. COUNTY 21-02			
1228 S. Carey St.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 1228 S. Carey St.							
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH July 15, 1889	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Gebhart				14. MOTHER'S MAIDEN NAME Carrie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Pauline Leonard 1324 Northview Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ACUTE CORONARY OCCLUSION				(A) DUE TO ACVD		minutes	
ANTECEDENT CAUSES				(B) DUE TO senile changes		years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)		months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov 16, 1965 to June 16, 1966 that (I) (we) last saw the deceased alive on June 16, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Henry Armanas M.D.				23B. DATE SIGNED July 6, 1966			
23C. PHYSICIAN'S NAME (Type) HENRY ARMANAS M.D.				23D. ADDRESS 1934 Wilkens Ave Balto, 23, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7 7 1966		24C. NAME of CEMETERY or CREMATORY Western		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT JUL 7 1966		25B. NAME OF REGISTRAR Robert E. Fulkerson		25C. FUNERAL DIRECTOR Mc Cully		ADDRESS 130 E. Fort Ave	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06840		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06840	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) EDNA WYATT			2. DATE AND HOUR OF DEATH 7-2-66 8:20 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL			A. STATE MARYLAND, BALTIMORE B. COUNTY Balto		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) ESSEX 53-00		
			D. STREET ADDRESS (If rural, give location) 406 406 MARYLAND AVE.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-15-21	9. AGE (In years lost birthday) 45	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME GEORGE STEEL			14. MOTHER'S MAIDEN NAME NANCY WHEATLEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. Oakley Wyatt (same as above)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Pulmonary Embolism (B) Pelvic Thrombophlebitis (C)		INTERVAL BETWEEN ONSET AND DEATH 1 day
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7/2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Wound dehiscence		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/22 1966 to 7/2 1966, that (I) (we) last saw the deceased alive on 7/2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harmon J Eyre M.D.				23B. DATE SIGNED 7/2/66	
23C. PHYSICIAN'S NAME (Type) Harmon J Eyre M.D.				23D. ADDRESS 550 No Broadway Baltimore Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7-4-66		24C. NAME of CEMETERY or CREMATORY Gardner	
24D. LOCATION (City, town, or county) (State) Chase Co. Virginia		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS Annally Funeral Home - 300 Grace Ave			

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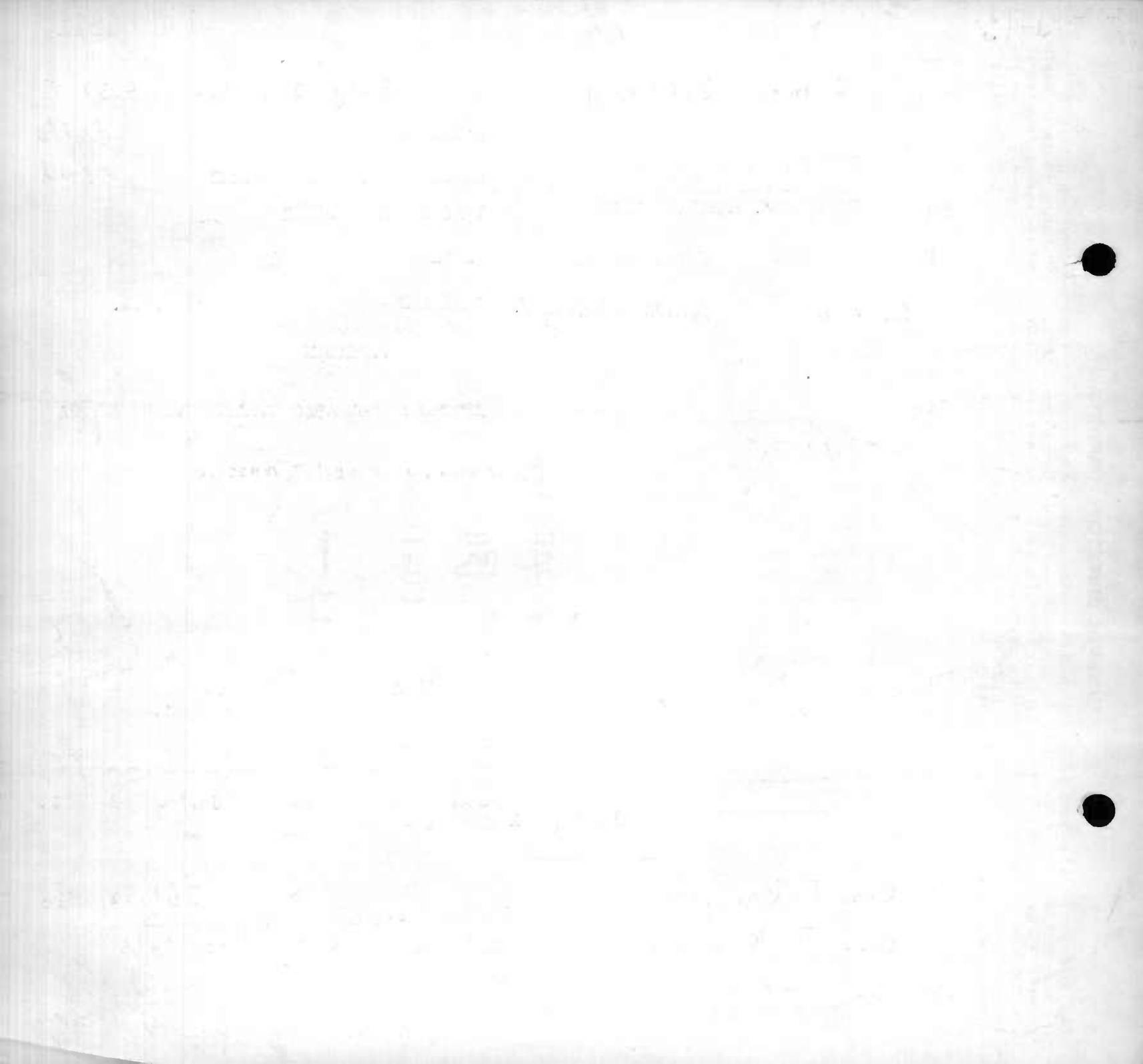
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 06841	
BIRTH NO. 66 06841		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Samuel Jeffery		2. DATE AND HOUR OF DEATH July 2, 1966 4:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION BAIT MORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND B. COUNTY Balto			
5. SEX MALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE COUNTY #21222 53-00			
8. DATE OF BIRTH 6-15-04 9. AGE (In years last birthday) 62				D. STREET ADDRESS (If rural, give location) 1940 GUYWAY #21222			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10B. KIND OF BUSINESS OR INDUSTRY Smith Bakery Co.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM				14. MOTHER'S MAIDEN NAME FERGUSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVENUE #21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Pulmonary embolus massive DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH -			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 15, 1966 to July 2, 1966, that (I) (we) last saw the deceased alive on July 2, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ross T. Krueger				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 2, 1966	
23C. PHYSICIAN'S NAME (Type) Ross T. Krueger				23D. ADDRESS 4940 EASTERN AVENUE #21224 Baltimore City Hospitals			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/66		24C. NAME OF CEMETERY OR CREMATORY Balto. National		24D. LOCATION (City, town, or county) Balto. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Connelly Sons 300 N. Ave. Balto. 21			



30-83-78

NIW 6-342

66 06842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

66 06842

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GODLEWSKI, VIOLA

2. DATE AND HOUR OF DEATH

7-5-66 11:20 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS

(If rural, give location)

1010 ROCKHILL AVENUE - 21229

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

11/25/94

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

AUSTRIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frank Domino

14. MOTHER'S MAIDEN NAME

Marie ??

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of)

*

*

16. SOCIAL

SECURITY NO.

218-03-8691

17. INFORMANT

ADDRESS

RECORDS: BCH, 4940 Eastern Ave., Balto, Md. 21224

18. 420.1 I

DISEASE OR CONDITION DIRECT
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, arising
rise to the above cause (A) still the
UNDERLYING CONDITION last.

CAUSE OF DEATH

Congestive Heart Failure

INTERVAL BETWEEN
ONSET AND DEATH

24 hours

(A) DUE TO

Brown atrophy of heart and

(B) DUE TO

Coronary artery atherosclerosis

(C) DUE TO

Congestive heart failure

20 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.NOT A MEDICAL EXAMINER'S CASE
CHIEF OR ASSISTANT MEDICAL EXAMINER

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-24 1966 to 7-5 1966.
that (I) (we) last saw the deceased alive on 7-5 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David B. Swimmer

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7-5-66

23C. PHYSICIAN'S
NAME (Type)

DAVID SWIMMER

M.D.

23D. ADDRESS BALTIMORE CITY HOSPITALS

4940 Eastern Avenue, Balto., Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/8/66

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION

(City, town or county)

(State)

Anne Arundel, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 7 1966 Robert E. Jenkins

M.F. SADOWSKI & SONS, 1808 EASTERN AVE.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

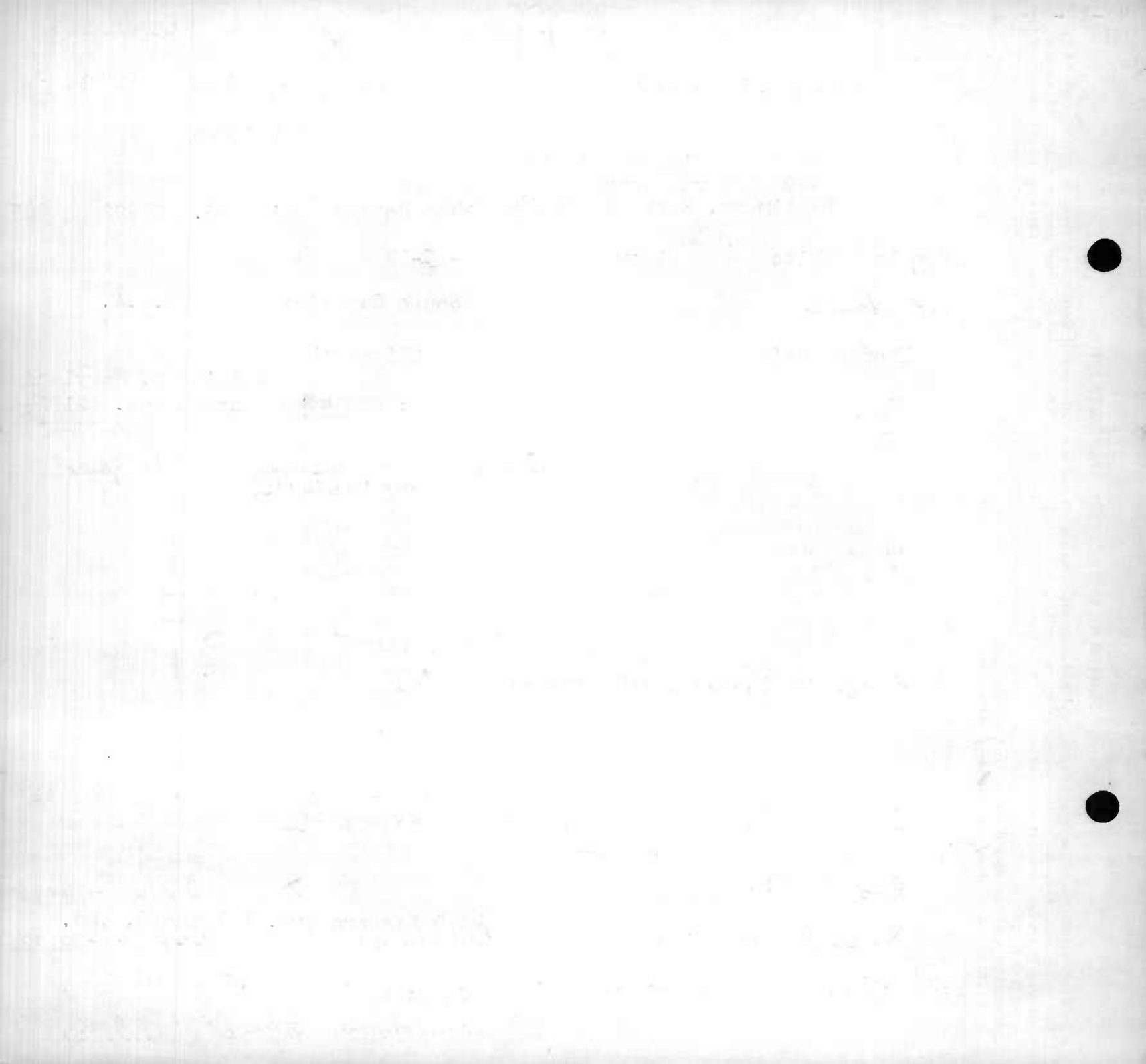
SEND TO: [illegible]

ADDRESS: [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. 66 06843		REGISTERED NO. 66 06843	
47-12-41 DH		J-635		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Harriet Jordan			2. DATE AND HOUR OF DEATH July 4, 1966 12:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			A. STATE Maryland B. COUNTY Baltimore -53-00		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
			3440 Sollers Point Rd. 21222 005		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 6-12-12	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Craig			14. MOTHER'S MAIDEN NAME Elizabeth		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Baltimore, Maryland RECORDS: BCH 4940 Eastern Ave. #21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Squamous cell carcinoma, metastatic			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 1 year		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION Aug 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Squamous cell carcinoma		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 3 1966 to July 4 1966 , that (I) (we) last saw the deceased alive on July 4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ross T. Krueger				23B. DATE SIGNED July 4, 1966	
23C. PHYSICIAN'S NAME (Type) Ross T. Krueger		23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. Baltimore City Hospital #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7/5/66		24C. NAME OF CEMETERY or CREMATORY Hopewell Baptist Church, Lancaster, S. C.	
24D. LOCATION (City, town, or county) (State) Baltimore		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Connelly Sons F. Home		25D. ADDRESS 300 Mace Ave. Balto. 21	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 06844		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06844	
BIRTH NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Reigle, Nellie Pearl</i>		7/5/66 6:10 A.M.	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		(If not in hospital or institution, give street address or location) <i>38 University of Maryland</i>		A. STATE <i>Md.</i> B. COUNTY <i>Anne Arundel</i>	
5. SEX <i>F</i>		6. RACE <i>White</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Harmans</i>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>March 16, 1888</i>		9. AGE (In years lost birthday) <i>78</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Reason Lowman</i>		14. MOTHER'S MAIDEN NAME <i>Savannah Turner</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Charles Reigle (Son) Same as #4</i>	
18. <i>492X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cardiac decompensation</i> DUE TO (B) <i>Septic shock</i> DUE TO (C) <i>pneumonitis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 hrs.</i> <i>24 hrs.</i> <i>72 hrs.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/4/66</i> 19 to <i>7/5/66</i> 19, that (I) (we) last saw the deceased alive on <i>7/5/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William A. Scovill</i>				23B. DATE SIGNED <i>7/5/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>William A. Scovill</i>				23D. ADDRESS <i>U. Hosp., U. of Maryland</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 8/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Epiphany Episcopal Ch. Cem. Odenton, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MA</i>		25C. FUNERAL DIRECTOR <i>Richard V. Singleton</i>	
				ADDRESS <i>Glen Burnie, Md.</i>	

37

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R-152

66 06845

BALTIMORE CITY HEALTH DEPARTMENT

66 06845

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HARRY H. ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD

1 July 1966 6:23 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2017 Eutaw Pl.

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

March 25, 1894

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Canton Railroad

11. BIRTHPLACE (State or foreign country)

Allegheny Co. Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Alexander Robinson

14. MOTHER'S MAIDEN NAME

Georgia Anna Gross

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
214-07-0181

17. INFORMANT

ADDRESS

Harry H. Robinson Jr. 4502 Mountview Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED20A. AUTOPSY? (Yes or No)
no20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/2/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 5, 1966

23C. NAME of CEMETERY or CREMATORY

Lakeview Memorial Park

23D. LOCATION

(City, town, or county)

(State)

Randallstown Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1966

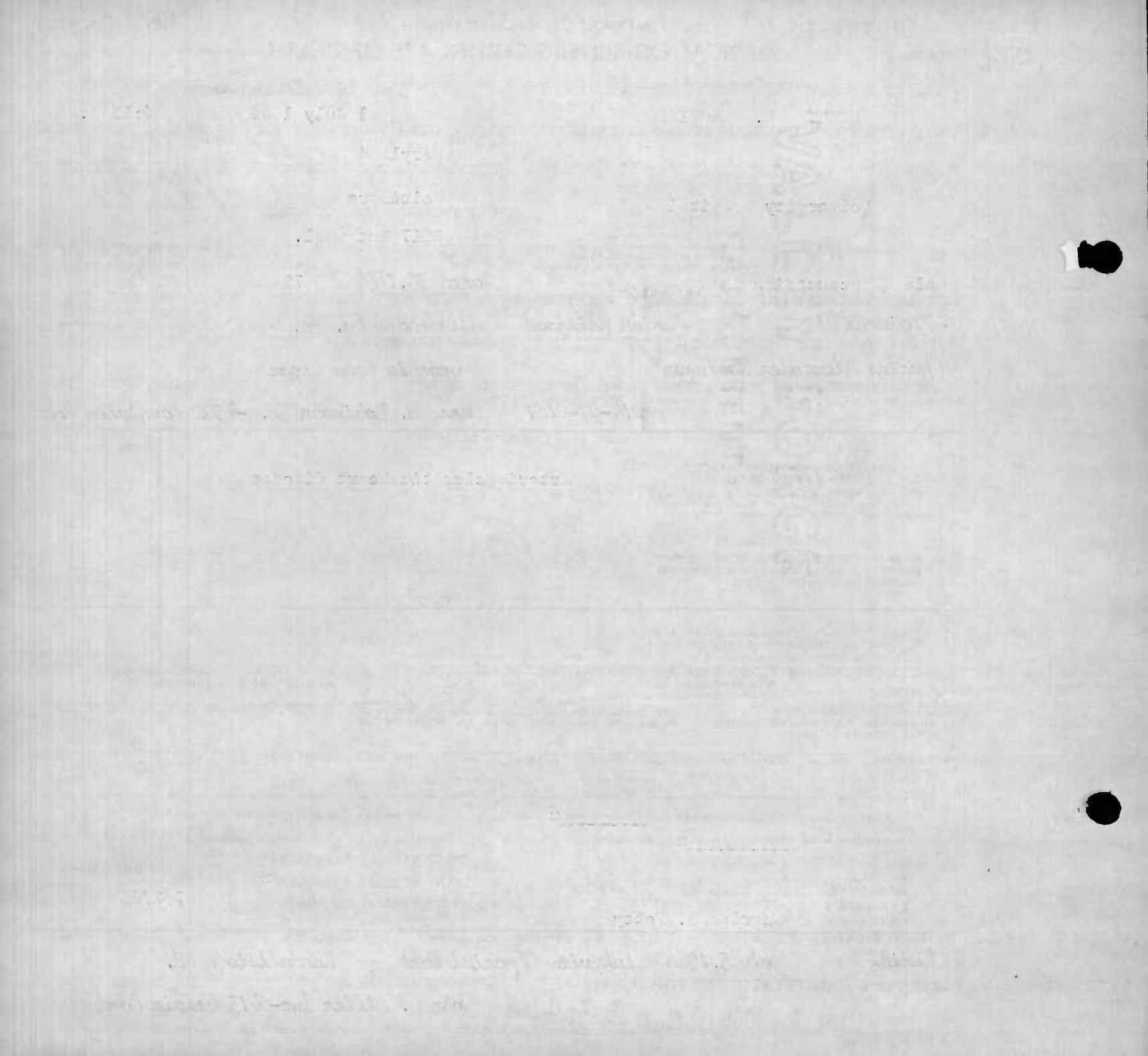
24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

John C. Miller Inc-415 Belair Road

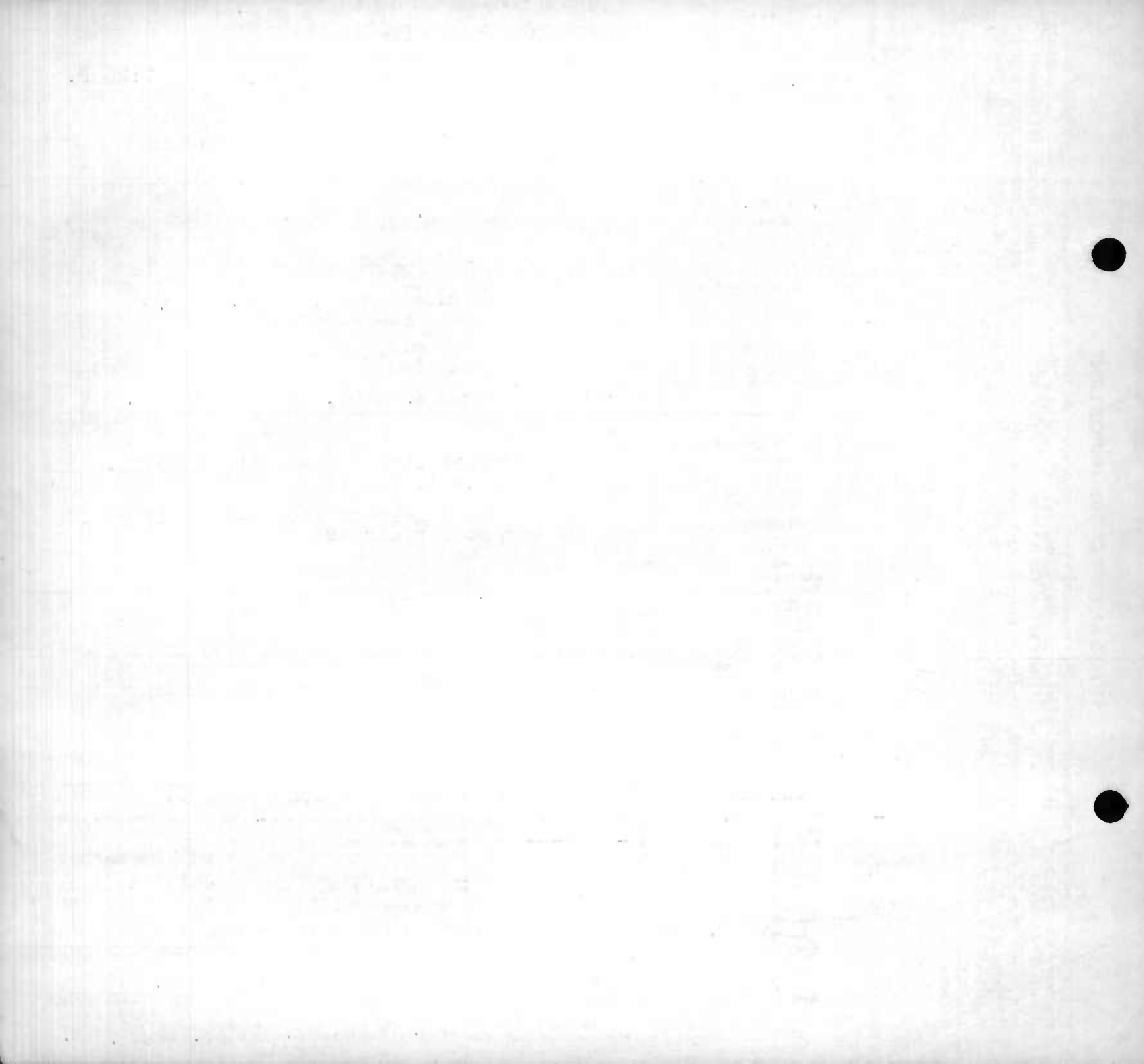
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06846		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06846	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Bertie S. Cully</i>		
2. DATE AND HOUR OF DEATH <i>July 5, 1966</i> <i>7:20 P.</i> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9-01</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>677 E. 41st. Street</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>677 E. 41st Street</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>8/19/1876</i>	9. AGE (In years last birthday) <i>89</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Lancaster County, Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John McClarigan</i>			14. MOTHER'S MAIDEN NAME <i>O'Connor</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. -----	17. INFORMANT ADDRESS <i>Oscar D. Cully, 1978 Knollton Rd.</i>		
18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Cerebral thrombosis with Hemiplegia (left)</i> (B) <i>Arteriosclerosis cardio-vascular disease</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>5 mo.</i> <i>15 yrs.</i>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>January</i> 19 <i>66</i> to <i>July 5,</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>July 5,</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lloyd E. Saylor</i>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>July 7, 1966</i>
23C. PHYSICIAN'S NAME (Type) <i>Lloyd E. Saylor</i>			23D. ADDRESS <i>3902 Greenmount Avenue</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>7/8/66</i>	24C. NAME of CEMETERY or CREMATORY <i>Marticville Methodist Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Marticville, Pa.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Saylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran, Inc. 3000 E. Balto. St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06847	
BIRTH NO. 66 06847		CERTIFICATE OF DEATH			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Mary Theresa Clifford			July 5, 1966 5 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Maryland B. COUNTY 2601		
90 Belair Nursing Home			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 5837 Belair Road		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	White	Single	Jan. 10, 1877	89	II Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thomas Edward Clifford			Anna McGarigle		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
			none		Elizabeth Harris 3214 Avon Avenue
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) Atherosclerotic cordis - vascular disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Terminal bronchopneumonia		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>)	
0				10 days.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Aug 1951 to July 5 1966 , that (I) (we) last saw the deceased alive on July 1, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer				23B. DATE SIGNED July 6, 1966	
23C. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER				23D. ADDRESS 6100 York Rd., Baltimore, Md. 21212	
24A. BURIAL CREMATION, REMOVAL (Specify)		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/7/66 New Cathedral Cemetery		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 7 1966		A. E. E. Farley, MA		John A. Moran, Inc. 3000 E. Balto. St	

1
M-450

66 06848

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 06848

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Charles MULLEN

2. DATE AND HOUR PRONOUNCED DEAD

July 4, 1966

2:35 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1000 Forrest Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1000 Forrest Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

July 4, 1900

9. AGE (In years
last birthday)

88-66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Guard

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Arthur T. Mullen

14. MOTHER'S MAIDEN NAME

Annie C. (McWilliams)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW 71

16. SOCIAL
SECURITY NO.

yes unknown Miss Jane M. Mullen 1642 Ralworth Rd.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 5, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/8/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery, Baltimore, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Baltimore St

ADDRESS

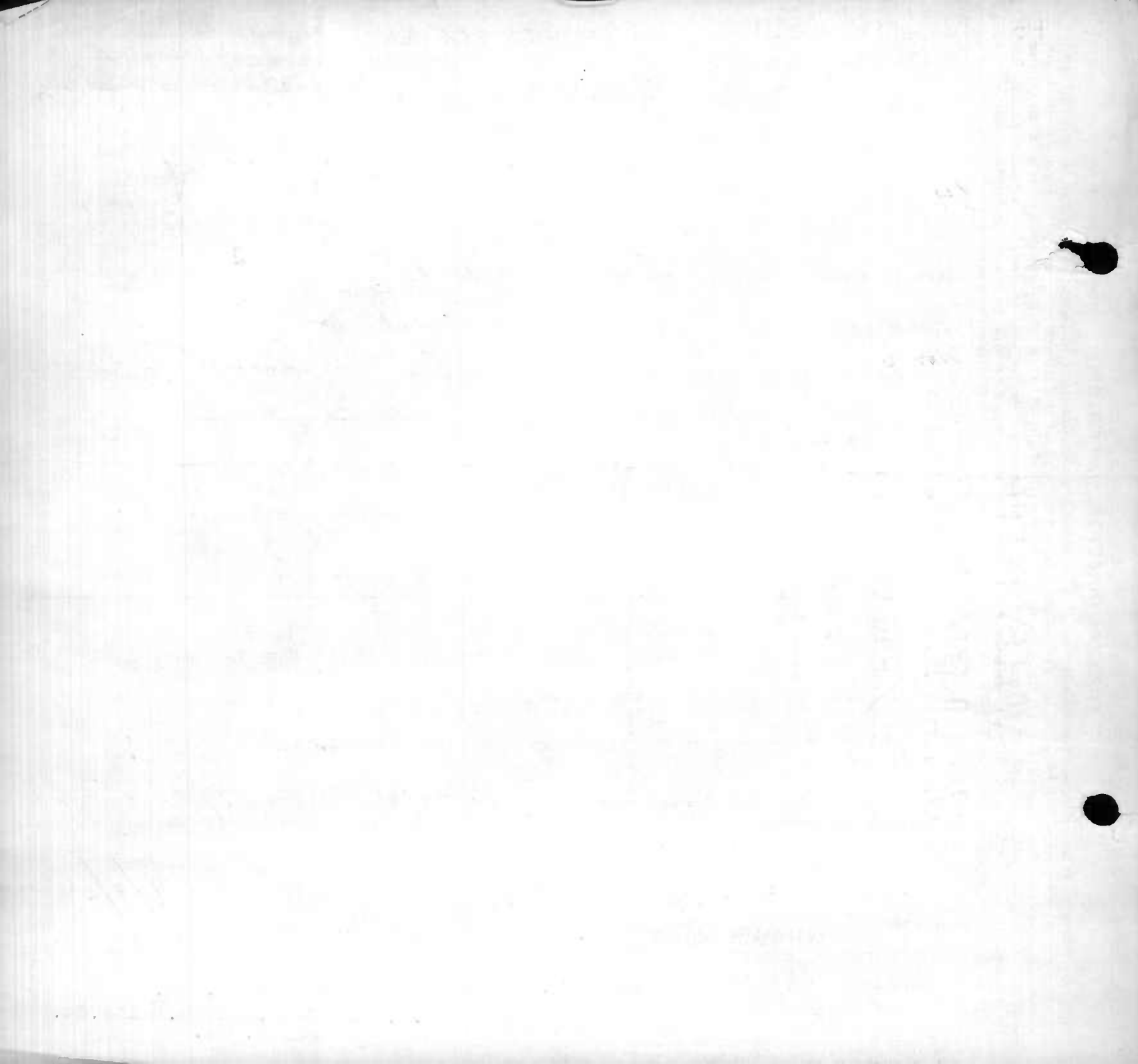
WALLLEY PUBLISHING

1000 1000 1000



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06849	
BIRTH NO. 66 06849					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Sollenberger Mrs. O TA</i>				2. DATE AND HOUR OF DEATH <i>July 2, 1966 11:50 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bon Secours Hospital</i>				A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 19-0423</i>	
				D. STREET ADDRESS (If rural, give location) <i>55 S. Monroe St.</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>1/2/04</i>	9. AGE (In years last birthday) <i>62</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <i>Jawford W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Wm. E. Reed</i>			14. MOTHER'S MAIDEN NAME <i>Rettie Prunty</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <i>332 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO <i>Cerebral Thrombosis</i> (B) DUE TO <i>Arteriosclerosis, generalized.</i> (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/2 6/24/66</i> 19 <i>66</i> to <i>7/2</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>7/2 19 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i> M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>7/2/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>AMABLE A. MENDOZA, M.D.</i>				23D. ADDRESS <i>Bon Secours Hosp</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/6/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Pk. Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>Fred. A. Cole</i> ADDRESS <i>Home, 1913 W. Balto. St. Balto. Md.</i>	



1
P-456

66 06850

BALTIMORE CITY HEALTH DEPARTMENT

66 06850

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Bertha PALMER

2. DATE AND HOUR PRONOUNCED DEAD

July 4, 1966 1:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1120 Stoddard Court

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1120 Stoddard Court

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 15, 1904

9. AGE (In years last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

William Rose

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

William Dailey 2119 Callow Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 4, 1966

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

7-7-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION (City, town, or county)

Balto.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1966

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Geo. Kelton

ADDRESS

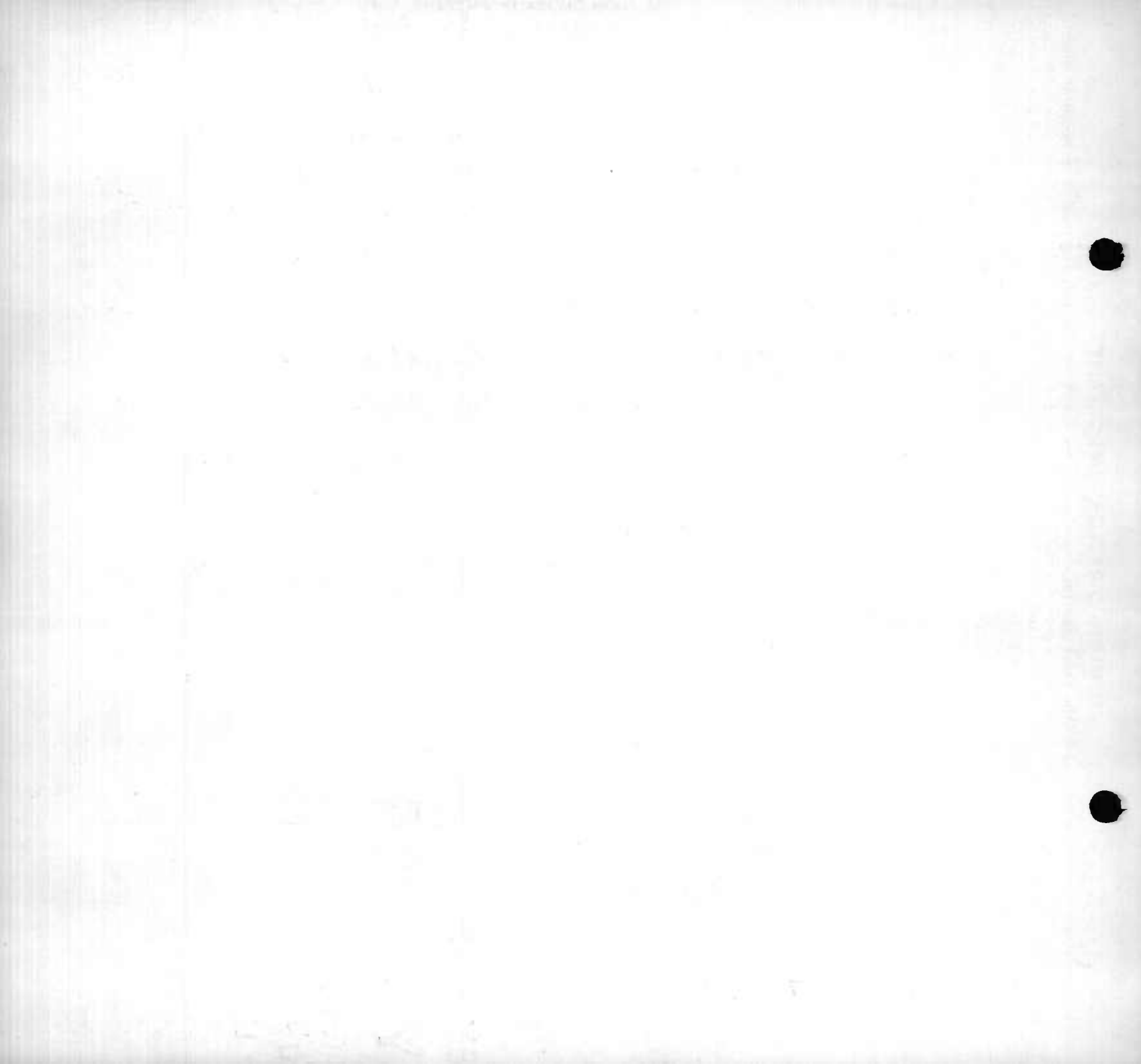
1348 Calhoun St.

VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06851		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06851	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Eva Literksi</i>		2. DATE AND HOUR OF DEATH <i>7/4/66</i> <i>5:30 A</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Midtown Home, Inc.</i>		A. STATE <i>MARYLAND</i>		B. COUNTY <i>1-03</i>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
		D. STREET ADDRESS (If rural, give location) <i>507 S. LAKEWOOD AVE.</i>			
6. SEX <i>female</i>	7. RACE <i>white</i>	8. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>SINGLE</i>	9. DATE OF BIRTH <i>7-8-1896</i>	10. AGE (In years last birthday) <i>69</i>	11. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PRESSER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>SHIRT FACTORY</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>ANTHONY LITERSKI</i>		14. MOTHER'S MAIDEN NAME <i>ROSALIE BRZOWSKI</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>219-16-2603</i>		17. INFORMANT <i>MRS. MARION SKOTOWSKI</i>	
18. <i>422.1 I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Cardio Respiratory Failure</i>			
ANTECEDENT CAUSES		(B) <i>Emphysema Heart Failure</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>Intercurrent CVD</i>			
		(D) <i>Parkinson's Disease</i>			
		(E) <i>Generalized Arteriosclerosis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 26</i> 19 <i>62</i> to <i>July 4</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>July 4</i> 19 <i>66</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.					
23A. SIGNATURE <i>William D Applepezo</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>William D Applepezo</i>	
23D. ADDRESS <i>5901 Park Heights Dr.</i>		23E. M.D.		23F. Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7-9-1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>ST. STANISLAUS CEMETERY</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MD.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1966</i>		24F. NAME OF REGISTRAR <i>Robert E. Fiedler</i>	
24G. FUNERAL DIRECTOR <i>RAYMOND L. KACZOROWSKI</i>		24H. ADDRESS <i>2525 FLEETS</i>		24I. M.D.	



27-83-49

NW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06852		BALTIMORE CITY HEALTH DEPARTMENT	
M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Lulu Dowes</u>		2. DATE AND HOUR OF DEATH <u>7/5/66</u> <u>6:05 pm</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>26-12</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND 21224</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
D. STREET ADDRESS <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue, Balto.Md. 21224</u>		E. STREET ADDRESS	
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>10-27-1890</u>
9. AGE (In years last birthday) <u>76</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	11. BIRTHPLACE (State or foreign country) <u>Pine. Bpo, N. C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Wesley Weaver</u>		14. MOTHER'S MAIDEN NAME <u>Georgianna Weaver</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		17. INFORMANT <u>RECORDS: BCH 4940 Eastern Ave. Balto. Md. 21224</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Vomitus Aspiration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/23</u> 19 <u>66</u> to <u>7/5</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/5</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>William Emerson</u>		23B. DATE SIGNED <u>7/5/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM EMERSON</u>		23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Ave., Balto. Md. 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7-11-66</u>	24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery Baltimore Md.</u>	24D. LOCATION (City, town, or county) (State) <u>Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1966</u>	25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>	25C. FUNERAL DIRECTOR <u>Morton E. Dyett F.H.</u>	
		ADDRESS <u>1701 Laurens St.</u>	

WILLIAM & ASSOCIATES
1111 1/2 BROADWAY
NEW YORK 10004

1
e-160

66 06853

BALTIMORE CITY HEALTH DEPARTMENT

66 06853

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNIE COOPER

2. DATE AND HOUR PRONOUNCED DEAD

7-6-66

7:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3911 Main Avenue

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MAR.

8. DATE OF BIRTH

2-22-1916

9. AGE (in years last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months; Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Nurse

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Nash Co. N.C.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John Alston

14. MOTHER'S MAIDEN NAME

Lillie Alston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr. Roger Cooper

ADDRESS

1841 Carrollton Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of neck
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive cardiovascular disease

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3400 Block - Garrison Blv'd

21D. TIME OF INJURY (APPROX.)

7 6 '66 AM 6:48

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver of car which struck tree

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-6-66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

7-11-66

23C. NAME of CEMETERY or CREMATORY

MT. CALVARY

23D. LOCATION (City, town, or county) (State)

A.A. Co.

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1966

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

MORTON + Dyett

ADDRESS

1701 LAURENS

WALLEY POLICE

FRAG. DOCUMENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06854	
BIRTH NO. 66 06854		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 7-2-66 4:20 A. M.	
1. NAME OF DECEASED (Type or Print) MR. CHARLES KRATZ			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
		D. STREET ADDRESS (If rural, give location) 136 OVERBROOK RD. (12)	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-24-90
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Court Stenographer Legal		9. AGE (In years last birthday) 76	11. BIRTHPLACE (State or foreign country) MARYLAND
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN KRATZ		14. MOTHER'S MAIDEN NAME JENNIE AUBEL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-32-7716	
		17. INFORMANT CHARLES T. KRATZ	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4-20-1 I		CAUSE OF DEATH (A) Bronchopneumonia, bilateral DUE TO (B) Coronary sclerosis with DUE TO Pericarditis of right coronary (C)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 6-22-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma - sigmoid	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-2-66 19 to 7-2-66 19, that (I) (we) last saw the deceased alive on 7-2-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Jose Ortiz		23B. DATE SIGNED 7-2-66	
23C. PHYSICIAN'S NAME (Type) JOSE ORTIZ		23D. ADDRESS CHURCH HOME + HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/66	
24C. NAME OF CEMETERY or CREMATORY Woodson Park Cemetery Baltimore, Maryland		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966		25B. NAME OF REGISTRAR Robert E. Jenkins	
		25C. FUNERAL DIRECTOR William E. Johnson	
		ADDRESS 8521 Loch Raven Blvd.	

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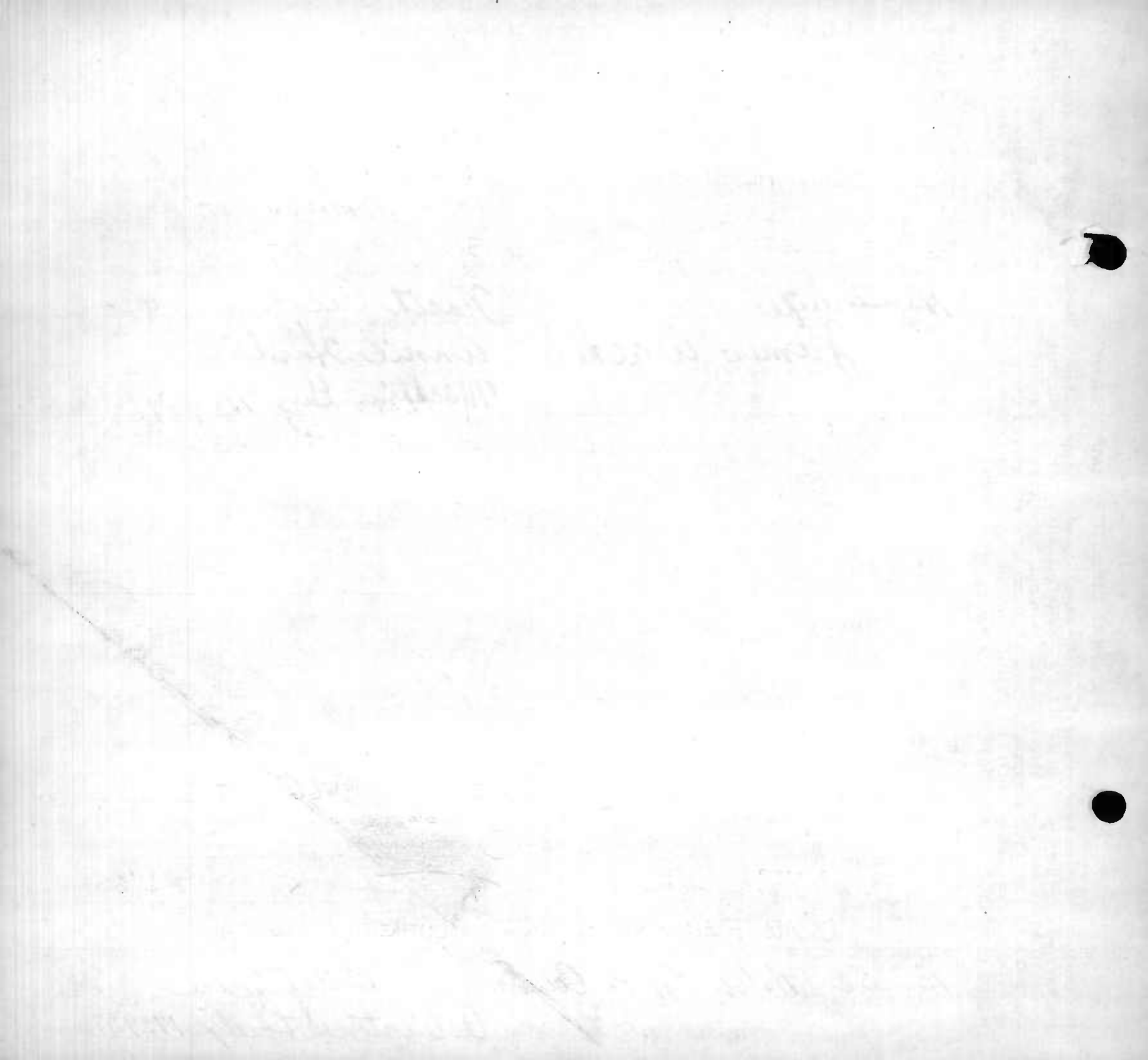
STAY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06855		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06855	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNIE GUY		2. DATE AND HOUR OF DEATH 7/2/66 3 40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland - B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 16-04 D. STREET ADDRESS (If rural, give location) 1004 Appleton St			
5. SEX FEMALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/25/19	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Walker		14. MOTHER'S MAIDEN NAME Annie Harding		17. INFORMANT Macklin Guy 1004 Appleton St.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	ADDRESS		
18. 1350 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH CARDIORRESPIRATORY FAILURE (A) DUE TO SARCOIDOSIS (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/5 19 66 to 7/2 19 66, that (I) (we) lost saw the deceased alive on 7/2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Oscar Fernandini				23B. DATE SIGNED 7/2/66	
23C. PHYSICIAN'S NAME (Type) OSCAR FERNANDINI		23D. ADDRESS LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/6/66	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR A. C. G. 2, Jr.		25C. FUNERAL DIRECTOR Arlington S. Phillips 1727 N. Monro St.	

JUL 7 1966



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06856		CERTIFICATE OF DEATH		Registered No. 66 06856	
1. NAME OF DECEASED (Type or Print) Hortense Riles				2. DATE AND HOUR OF DEATH July 4, 1966 9:25 P.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland 21217				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, with RURAL and give township) 13-03 D. STREET ADDRESS (If rural, give location) 1376 W. North Avenue					
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-17-29	9. AGE (In years last birthday) 35	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Rose				14. MOTHER'S MAIDEN NAME Emma Perry					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Riles		ADDRESS 1376 W. North Ave		
18. 6483 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Ante cedent causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Acute metastizing Endometrial DUE TO (B) Acute edema of lungs DUE TO (C) Pulmonary embolism				INTERVAL BETWEEN ONSET AND DEATH 4 days 1 day 5 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Maternity - Caesarean Secti and me 7/5/66									
19A. DATE OF OPERATION 3/7/1/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Maternity		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 11/15/66 at home - pregnancy					
22. I certify that (I) (this hospital) attended the deceased from June 30, 1966 to July 4, 1966 that (I) (we) last saw the deceased alive on July 4, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE N. Louise Young				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 5, 1966			
23C. PHYSICIAN'S NAME (Type) N. Louise Young		M.D.		23D. ADDRESS 1100 Druid Hill Avenue					
24A. BURIAL CREMATION, REMOVAL (Specify) removal		24B. DATE 7-7-66		24C. NAME OF CEMETERY or CREMATORY Cross Road Cemetery N.C.		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966		25B. NAME OF REGISTRAR Robert E. Forney		25C. FUNERAL DIRECTOR Arlington Phillips		ADDRESS 1721 W. Howard St.			

1921 Division Street
Baltimore, Maryland 21202

Wanted - \$1000
Mortgage

9-17-50

W.C.

day

July 11, 1950
June 27, 1950

July 11, 1950

x

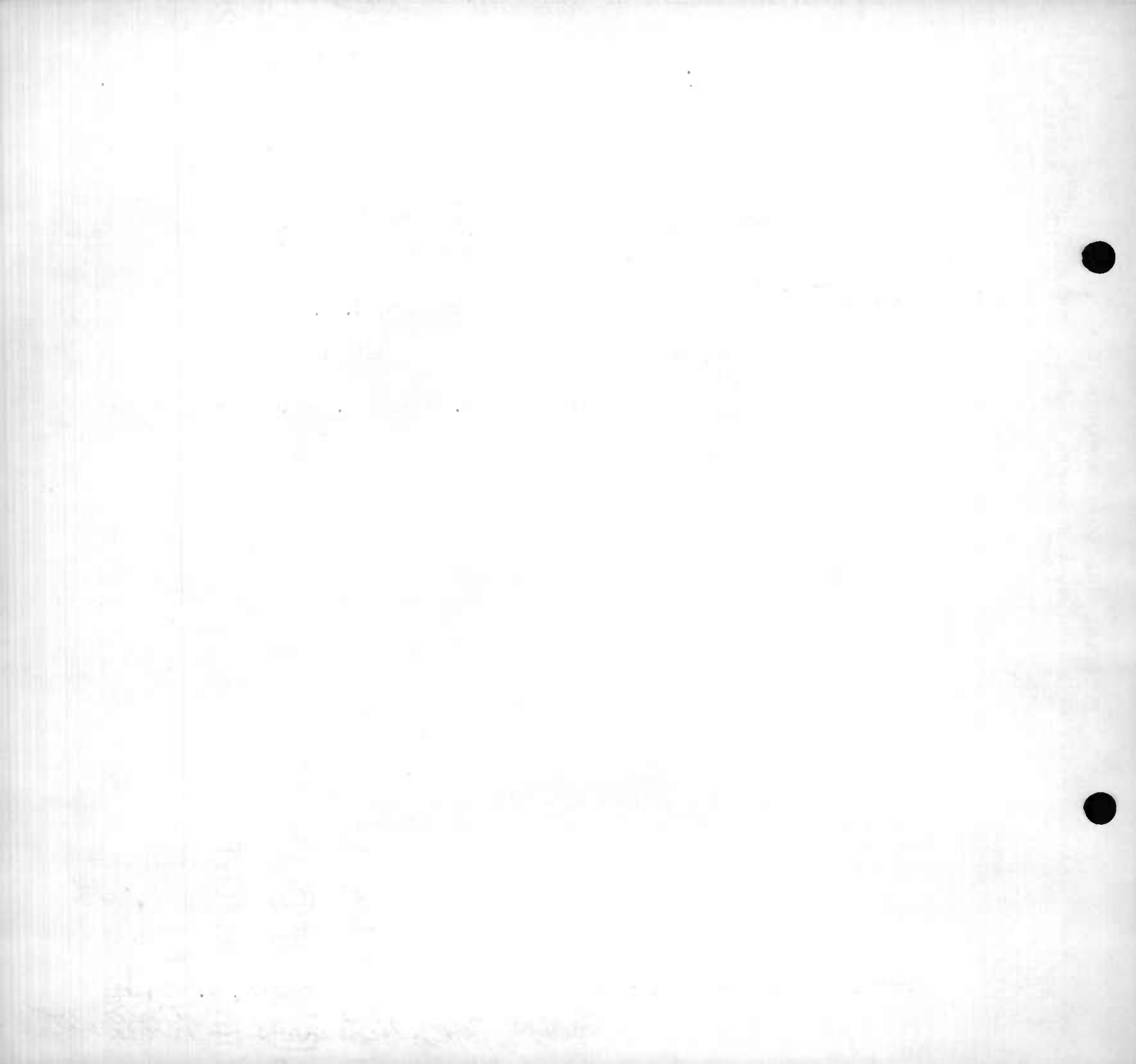
1100 North Hill Avenue

W. James Town

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 06857				
BIRTH NO. 66 06857					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) A. BERYL GAYLORD					2. DATE AND HOUR OF DEATH 7-6-66 3.10 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL					A. STATE WEST VIRGINIA				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) CLARKSBURG				
					D. STREET ADDRESS (If rural, give location) 475 WASHINGTON AVENUE				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 2-7-10	9. AGE (In years lost birthday) 56	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brooklyn, N. Y.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME HAROLD WILLIAMS					14. MOTHER'S MAIDEN NAME AKMEDIA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Charles A. Gaylord				ADDRESS same address
18. 356 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Cerebellar degeneration DUE TO			INTERVAL BETWEEN ONSET AND DEATH years	
					(B) _____ DUE TO				
					(C) _____ DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 7/5 19 66 to 7/6 19 66 , that (I) (we) last saw the deceased alive on 2:40 7/6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Tah-Hsiung Hsueh					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/6/66		
23C. PHYSICIAN'S NAME (Type) Tah-Hsiung Hsueh					23D. ADDRESS The Johns Hopkins Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7/7/1966		24C. NAME OF CEMETERY or CREMATORY Elkview Cemetery		24D. LOCATION (City, town, or county) (State) Clarksburg, W. Virginia			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966			25B. NAME OF REGISTRAR Robert E. Farber, M.D.			25C. FUNERAL DIRECTOR Wm. J. Tichner & Sons			
ADDRESS Baltimore, Md.									



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G-432

66 06858

BALTIMORE CITY HEALTH DEPARTMENT

66 06858

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FELIX GLADYSK

2. DATE AND HOUR PRONOUNCED DEAD

1 July 1966

9:12 p. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1803 Fleet St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1803 Fleet St.

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Not Known

8. DATE OF BIRTH

5/7/1888

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seaman

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Not Known

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

217-03-0125

17. INFORMANT

William E. Kelly 6520 Walters Ave B2

ADDRESS

18.

420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/2/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/6/66

23C. NAME of CEMETERY or CREMATORY

Balto Nat.

23D. LOCATION

Balto. XXXX Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1966

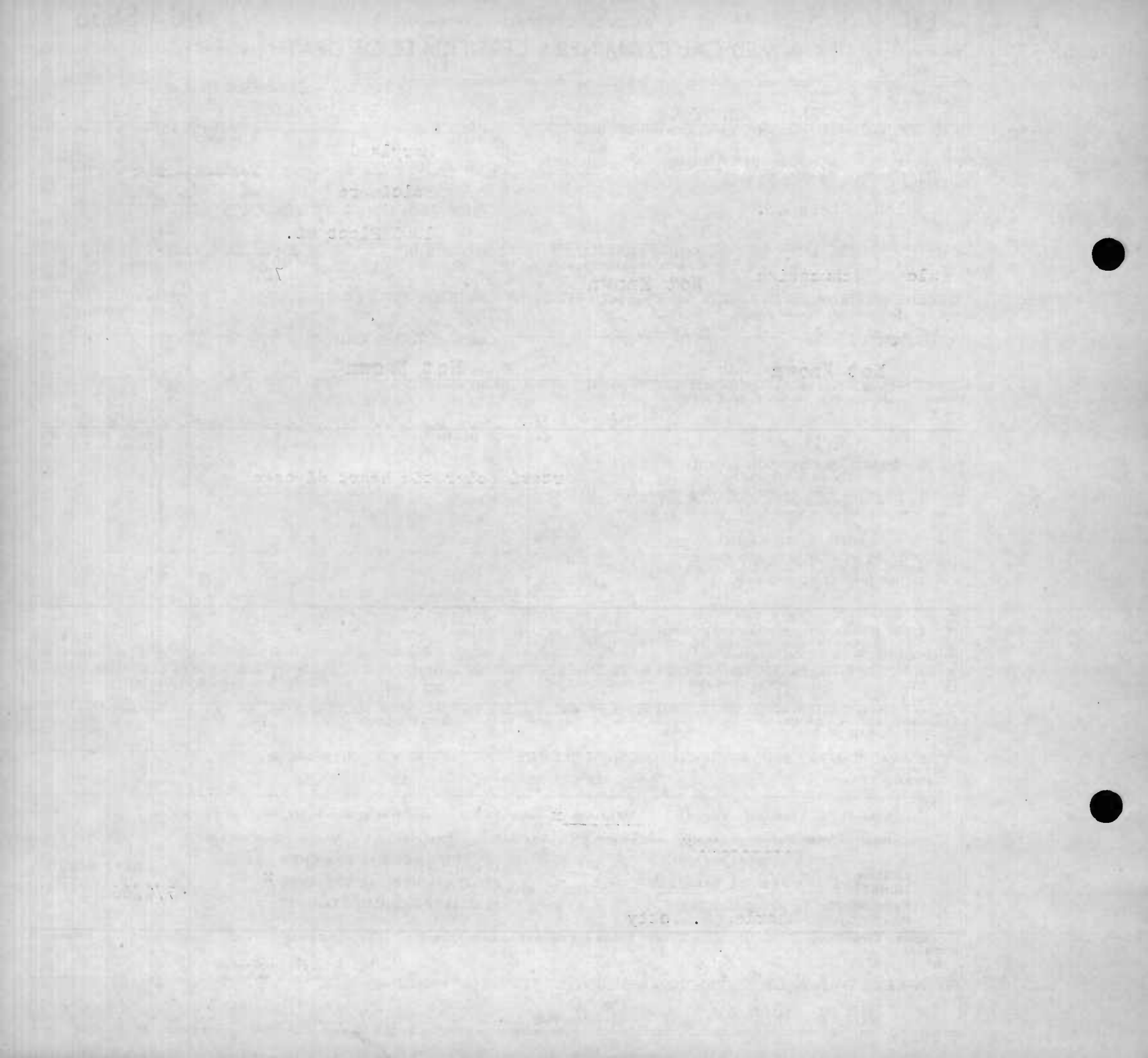
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Frank Della Rocca 322 S. High St.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06859		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06859	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Camillo D. Di Battista</u>		2. DATE AND HOUR OF DEATH <u>7-5-66</u> <u>1:20</u> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u>		A. STATE <u>MARYLAND</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>831 S. Grundy St.</u>			
5. SEX <u>m</u>	6. RACE <u>w</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH <u>May 26-1903</u>	9. AGE (In years last birthday) <u>63</u>	10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manten. Dep.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>B.S.W. (Sparr. Pt. Md) Italy</u>			
13. FATHER'S NAME <u>Daniel Di Battista.</u>		14. MOTHER'S MAIDEN NAME <u>Maria Rulli</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-07-3369</u>		17. INFORMANT ADDRESS <u>Mrs. Ida Di Battista-831 S. Grundy St.</u>	
18. <u>420.141260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>MYOCARDIAL INFARCTION</u> DUE TO (B) <u>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 hr</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>DIABETES MELLITUS</u>		<u>?</u>	
19A. DATE OF OPERATION <u>2 None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>10 AM 7/5 1966</u> to <u>2 PM 7/5 1966</u> , that (1) (we) last saw the deceased alive on <u>2 PM 7/5 1966</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>L. Bruce Gerber, M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7/5/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. BRUCE GERBER, M.D.</u>		23D. ADDRESS <u>8045 Woodgate Ct, Balt., Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 8-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLY Redeemer Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>4430 Belair Rd.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>	
25C. FUNERAL DIRECTOR <u>Frank Della Nave</u>		ADDRESS <u>3225 High St</u>			

11

11-11-11

11-11-11

11-11-11

11-11-11

1
14-420

66 06860

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 06860

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Walter K. Holokai, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

7/5/66 9:45 a. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Balto.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.-rural #21

D. STREET ADDRESS (If rural, give location)

464 Barrison Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

June 17, 1918.

9. AGE (In years
lost birthday)

48

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Assembly Man

10B. KIND OF BUSINESS OR INDUSTRY

Fisher Body Co.

11. BIRTHPLACE (State or foreign country)

Hawaii

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

HARRY Holokai

14. MOTHER'S MAIDEN NAME

HATTIE Unknown MOIKEHA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 2

16. SOCIAL
SECURITY NO.

576-10-8681

17. INFORMANT

Mrs. Ethel M. Holokai

ADDRESS

1813 Aberdeen Rd
Balto. Md. #34

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/5/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/8/66

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

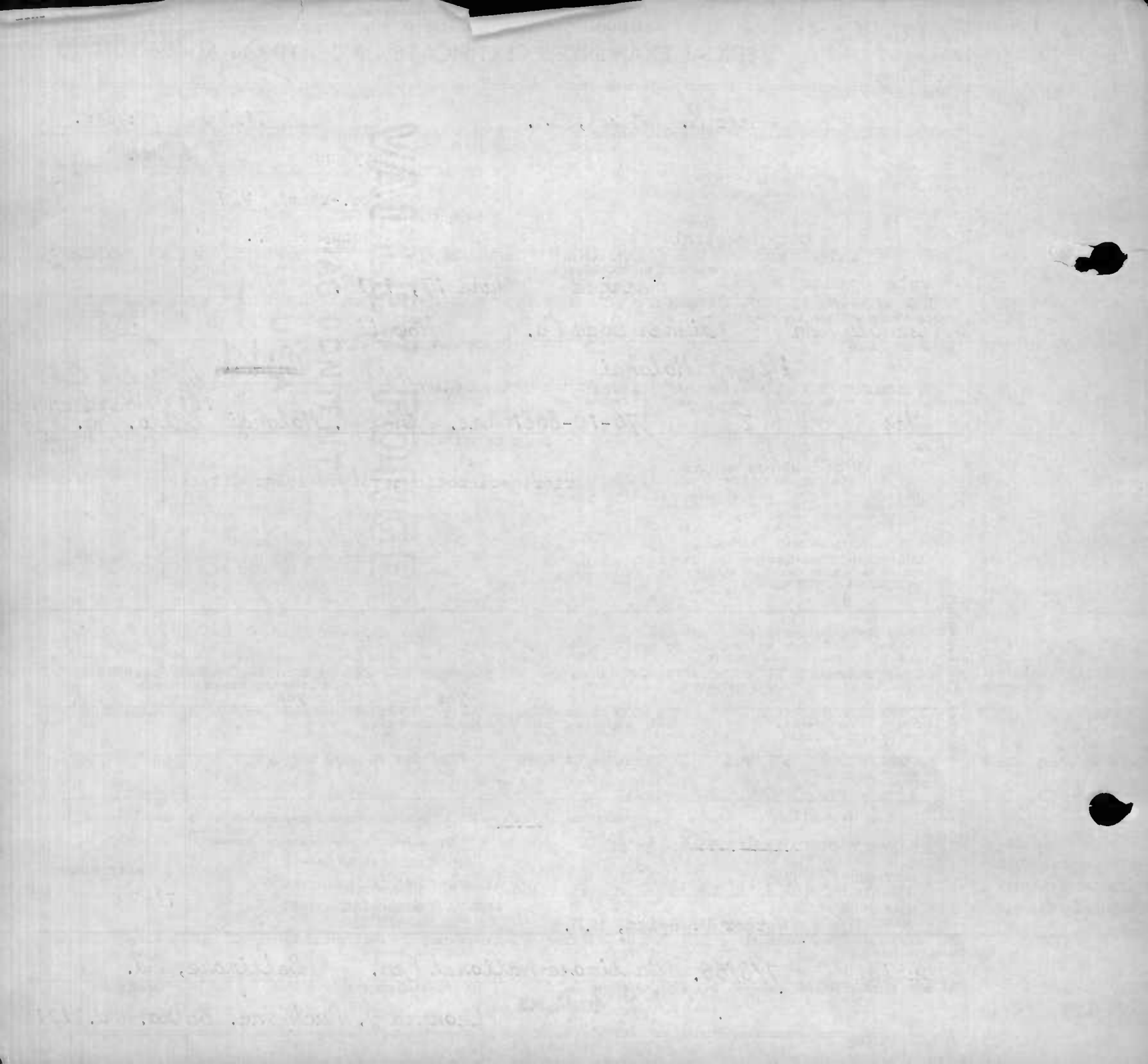
24C. FUNERAL DIRECTOR

ADDRESS

JUL 7 1966

Robert E. Taylor, M.D.

Leonard J. Ruck Inc. Balto. Md. 21214



FUNERAL DIRECTOR: IMPORTANT

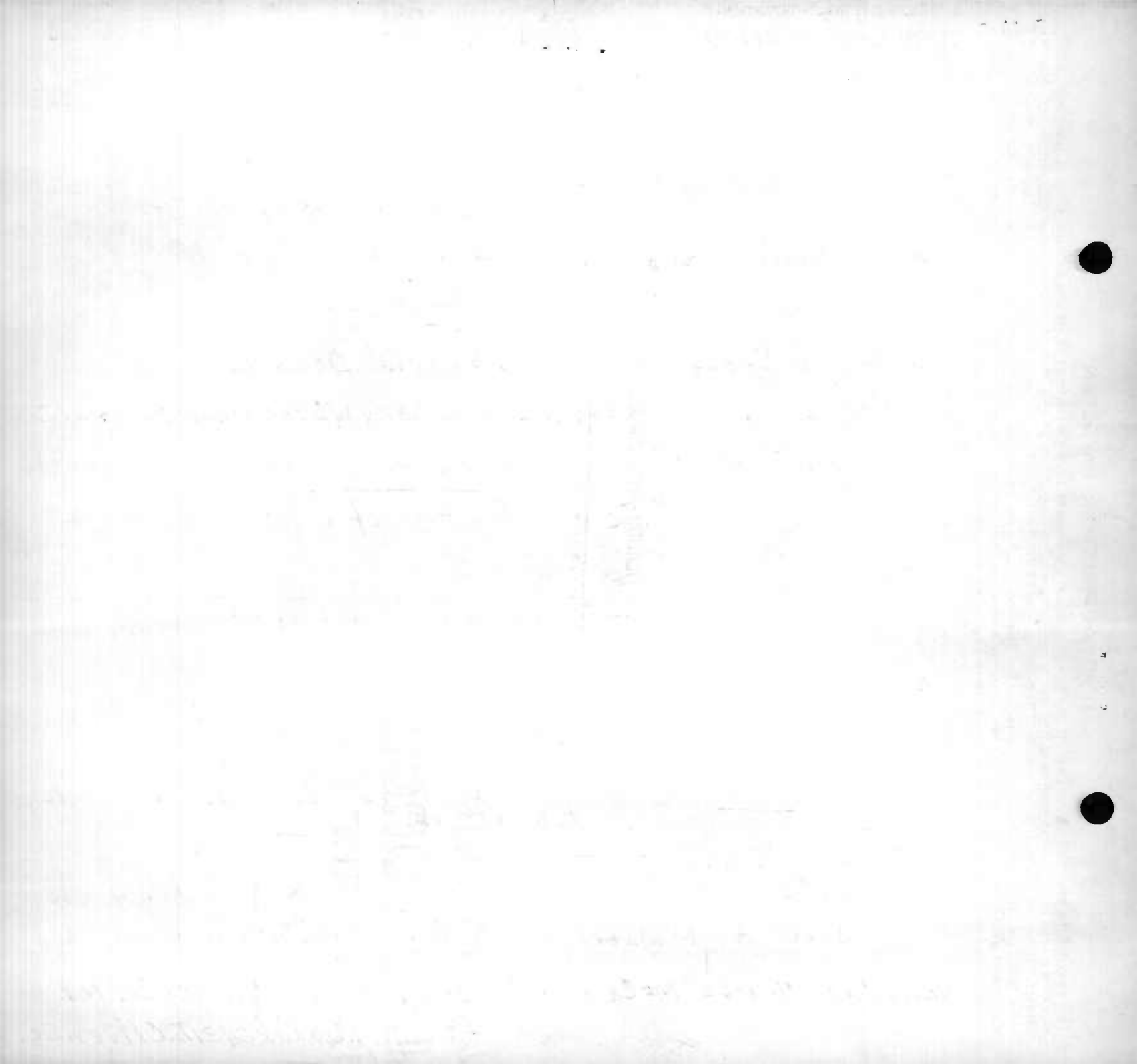
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06861		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06861	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Marie Bordes		2. DATE AND HOUR OF DEATH July 5, 1966		2:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harford Gardens Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson D. STREET ADDRESS (If rural, give location) 933 Cromwell Bridge Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Oct. 13, 1878	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? Germany		13. FATHER'S NAME Adan L. Gutberlet		14. MOTHER'S MAIDEN NAME Ernestine T. Eckstein	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 185-23286		17. INFORMANT Mr. Nick L. Bordes	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Heat Exhaustion		CAUSE OF DEATH (A) DUE TO Anteriosclerotic Cardio-vascular Disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> <div style="width: 20%; text-align: center;"> <p>CERTIFICATION APPROVED BY</p> <p>CHIEF OR ASST. MEDICAL EXAMINER</p> </div> <div style="width: 40%;"> <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> </div>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Harford Gardens Nursing Home	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7/3/66 ?		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? High environmental temperature.	
22. I certify that (I) (this hospital) attended the deceased from Feb 19 64 to July 19 66 , that (I) (we) last saw the deceased alive on July 5 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Loy M. Zimmerman				23B. DATE SIGNED 7/6/66	
23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman				23D. ADDRESS M.D. 3202 Harford Rd, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/66		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION Balto., Md.		24E. DATE REC'D BY HEALTH DEPT. JUL 7 1966		24F. NAME OF REGISTRAR Robert E. Farber	
24G. FUNERAL DIRECTOR Leonard J. Ruck Inc.		24H. ADDRESS Balto. Md. 21214			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06862		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06862	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) William McCross				2. DATE AND HOUR OF DEATH July 4, 1966 8:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital				A. STATE Maryland B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 19-01			
				D. STREET ADDRESS (If rural, give location) 507 N. Stricker St.			
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 4-6-03	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Wade McCross				14. MOTHER'S MAIDEN NAME Amanda Douglas			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 013-49-0195		17. INFORMANT Mrs. Mary White 2825 F. Federal St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO Hypostatic pneumonia		4-20-66 to	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Fracture of right hip		7-4-66	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO Hypertension of unknown origin			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 20 1966 to July 4 1966, that (I) (we) last saw the deceased alive on July 3 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Malabrigo				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 4, 1966	
23C. PHYSICIAN'S NAME (Type) Joel A. Malabrigo M.D.				23D. ADDRESS 40 Provident Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-66		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966		25B. NAME OF REGISTRAR Robert E. Fulkerson		25C. FUNERAL DIRECTOR Randolph J. Collick		ADDRESS 2431 E. Oliver St.	



66 06853

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 06853

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE WILLISON

2. DATE AND HOUR PRONOUNCED DEAD

2 July 1966 3:45 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2318 Arbuton Ave.

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Sept 5, 1938

9. AGE (In years
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Trk Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Everett Willison

14. MOTHER'S MAIDEN NAME

Ellen Witt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Family

ADDRESS

ame

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Hanging
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

hospital

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Church Home and Hospital

21D. TIME
OF INJURY
(APPROX.)

July 2, 1966 2:20 a.m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Hung self with belt

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/2/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/5/66

23C. NAME of CEMETERY or CREMATORY

Meadowridge Cem

23D. LOCATION

(City, town, or county)

Howard Co

Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 7 1966

Charles S. Petty

McCully FH 237 Patapsco Ave

25

NATIONAL POLICE

S-160

66 06864

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 06864

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH L. SHAFFER

2. DATE AND HOUR PRONOUNCED DEAD

X 1 July 1966

4:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2301 Cedley St.

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Jan 24, 1938

9. AGE (In years
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Birth Steel

10B. KIND OF BUSINESS OR INDUSTRY

S. P.

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles E.

14. MOTHER'S MAIDEN NAME

Frances Manayrd

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) cervical spinal cord compression
DUE TO

(C) fracture of cervical vertebra C-4

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

beach

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Cottage Grove Beach, Pasadena, Md.

21D. TIME
OF INJURY
(APPROX.)

June 23, 1966 7:30 p.m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

dove into shallow water

52-00

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/2/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-8-66

23C. NAME of CEMETERY or CREMATORY

Green Haven Cem

23D. LOCATION

(City, town, or county)

(State)

Green Haven Md

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1966

24B. NAME OF REGISTRAR

Robert E. Farkner, M.D.

24C. FUNERAL DIRECTOR

McCully - 2376 Patterson Ave

ADDRESS

1941

1942

1943

1944

1945

1946

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1950

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1952

1953

1954

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1956

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06865				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06865	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARIAN HAYBA				2. DATE AND HOUR OF DEATH July 4, 1966 9:55 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SO. BALTO. GEN. HOSP.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 1000 S. LIGHT ST.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-30-92	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JACK STEPHANS				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.			16. SOCIAL SECURITY NO. 216-10-4613		17. INFORMANT ADDRESS 1000 S. LIGHT ST. BALTO. MD. 21230		
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia, left ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Arteriosclerotic heart disease		years.	
19A. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? -		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (I) (this hospital) attended the deceased from July 4 - 1966 to July 4 - 1966 , that (I) was lost saw the deceased alive on July 4 - 1966 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) view the body after death.							
23A. SIGNATURE C. C. Chiu M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-5-66	
23C. PHYSICIAN'S NAME (Type) CHI-CHAO CHIU M.D.				23D. ADDRESS 1 E. Randall St. Baltimore 21230			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-6-66		24C. NAME of CEMETERY or CREMATORY BALTO. NAT'L. Cem.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Wm. Fialkowski		ADDRESS 2007 Eastern	

75

UNKNOWN

STEPHENS

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 06866					CERTIFICATE OF DEATH		Registered No. 66 06866		
BIRTH NO. 66 06866					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) LUBERECKI Anthony A.					2. DATE AND HOUR OF DEATH 7/4/66 2:01 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital of 16 City of Baltimore					A. STATE Md B. COUNTY Baltimore				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 1-03					D. STREET ADDRESS (If rural, give location) 525 S. LAKEWOOD AVE.				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6-17-01	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE FITTER			10B. KIND OF BUSINESS OR INDUSTRY Steel industry		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME FRANK LUBERECKI					14. MOTHER'S MAIDEN NAME JULIA DORKOWSKI				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 8-108-3541		17. INFORMANT ANNA LUBERECKI ADDRESS 525 S. LAKEWOOD AVE. BALTO. MD. 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Bronchitis-Emphysema					CAUSE OF DEATH XXXXXXXXXXXX		INTERVAL BETWEEN ONSET AND DEATH 22 hours		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO XXXXXXXXXXXX		(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Heat Stroke					(C) DUE TO XXXXXXXXXXXX				
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? 525 S. Lakewood Ave.		If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 7/3/66 4:00 P.M.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? High environmental temperature					
22. I certify that (I) (this hospital) attended the deceased from 7/3/66 19 7/4 19 66 , that (I) (we) last saw the deceased alive on 7/4 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE John Martinez 100, N Broadway M.D. John Martinez					23B. DATE SIGNED 7/4/66			23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-8-66		24C. NAME OF CEMETERY ST. STANISLAUS		24D. LOCATION (City, town, or county) (State) BALTO. MD.			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966		25B. NAME OF REGISTRAR Robert E. Farkowski		25C. FUNERAL DIRECTOR W. FIALKOWSKI		ADDRESS BALTO. 2007 EASTERN AVE. MD.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 06867					CERTIFICATE OF DEATH					Registered No. 66 06867				
1. NAME OF DECEASED (Type or Print) COX, LYNFORD ARTHUR					2. DATE AND HOUR OF DEATH 7/4/66					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Bolte				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					5. SEX M 6. RACE CAUCASIAN 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED					8. DATE OF BIRTH 10/05/16 9. AGE (in years last birthday) 49				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					D. STREET ADDRESS (If rural, give location) 276 E. SUSQUEHANNA AVE.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN					10B. KIND OF BUSINESS OR INDUSTRY SEARS ROEBUCK & LIBERTY, N.Y.					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME ARTHUR COX COMPANY					14. MOTHER'S MAIDEN NAME MARRIETT MURKINE					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none				
16. SOCIAL SECURITY NO. 120-01-1670					17. INFORMANT CINAT E. FAMILY					ADDRESS				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PULMONARY EDEMA DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SEPTIC SHOCK DUE TO URETERAL STONE										INTERVAL BETWEEN ONSET AND DEATH 7/3-7/4 7/3-7/4 7/1				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE														
19A. DATE OF OPERATION 7/2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED STONE EXTRACTION					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 7/1 19 66 to 7/4 19 66 , that (I) (we) last saw the deceased alive on 7/4 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE J. D. Haines					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 7/4/66				
23C. PHYSICIAN'S NAME (Type) JOHN S. HAINES, D.R. JOHN S. HAINES					23D. ADDRESS 11 E. CHASE STREET, COCKEYSVILLE, MD.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 7/7/66					24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Gardens				
24D. LOCATION (City, town, or county) (State) Cockeysville, Md.					25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966					25B. NAME OF REGISTRAR Robert E. Taylor, MD				
25C. FUNERAL DIRECTOR John Burns Sons					ADDRESS Towson, Md.									

DATE: 10/10/1964

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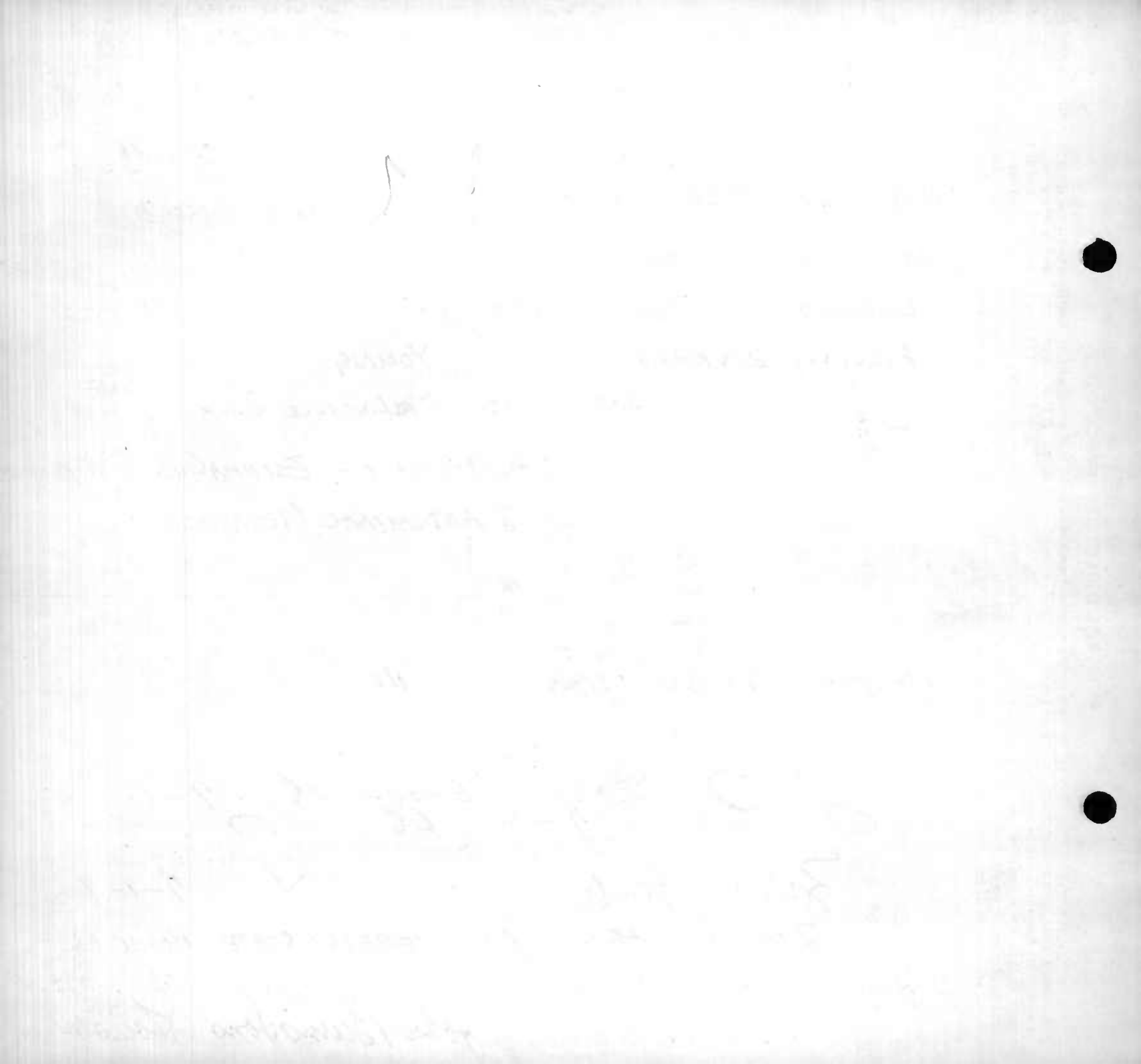
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

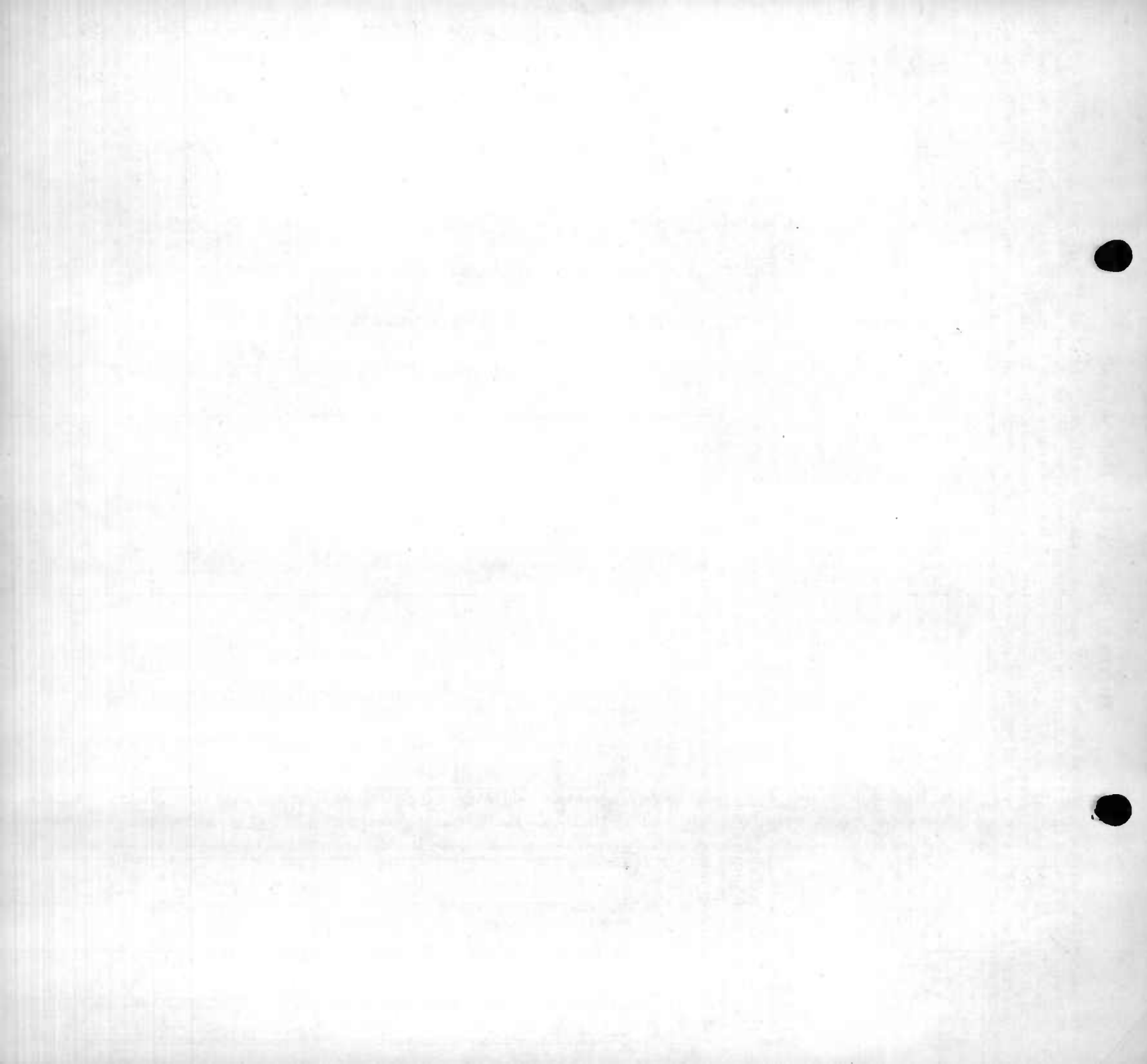
BALTIMORE CITY HEALTH DEPARTMENT											
66 06868					66 06868						
BIRTH NO.					M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH						
ZINKHAN, MR. CHARLES F.					7-1-1966 12 30 P.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY						
BALTIMORE. MONTEBELLO STATE HOSPITAL.					MARYLAND Baltimore						
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					BALTIMORE 34 53-00						
D. STREET ADDRESS (If rural, give location)					10101 HARFORD ROAD						
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)			
M		W		MARRIED		10-15-1914		51			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
LABORER			FLORIST HELPER			BALTIMORE, MD.			U. S. A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
WILLIAM ZINKHAN					YOUNG						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
					217-03-4180		MR. LUCILLE ZINKHAN			SAME (WIFE)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH	
150X I					CARCINOMA OF ESOPHAGUS					5 MONTHS	
ANTECEDENT CAUSES					(B) ABDOMINAL METASTASIS						
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)						
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
4-5-66			(B) COLOON BYPASS			NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR?			(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								
22. I certify that (I) (this hospital) attended the deceased from 6-21-1966 to 7-1-1966, that (I) (we) last saw the deceased alive on 7-1-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE					23B. DATE SIGNED						
ZIN U. PARK					7-1-66						
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS						
ZIN U. PARK					MONTEBELLO STATE HOSPITAL						
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE			24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
BURIAL			7-5-66			PROSPECT HILL			TOWSON, Md 21204		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS		
JUL 7 1966			Robert E. Farber, M.D.			John Burns Sons			TOWSON		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

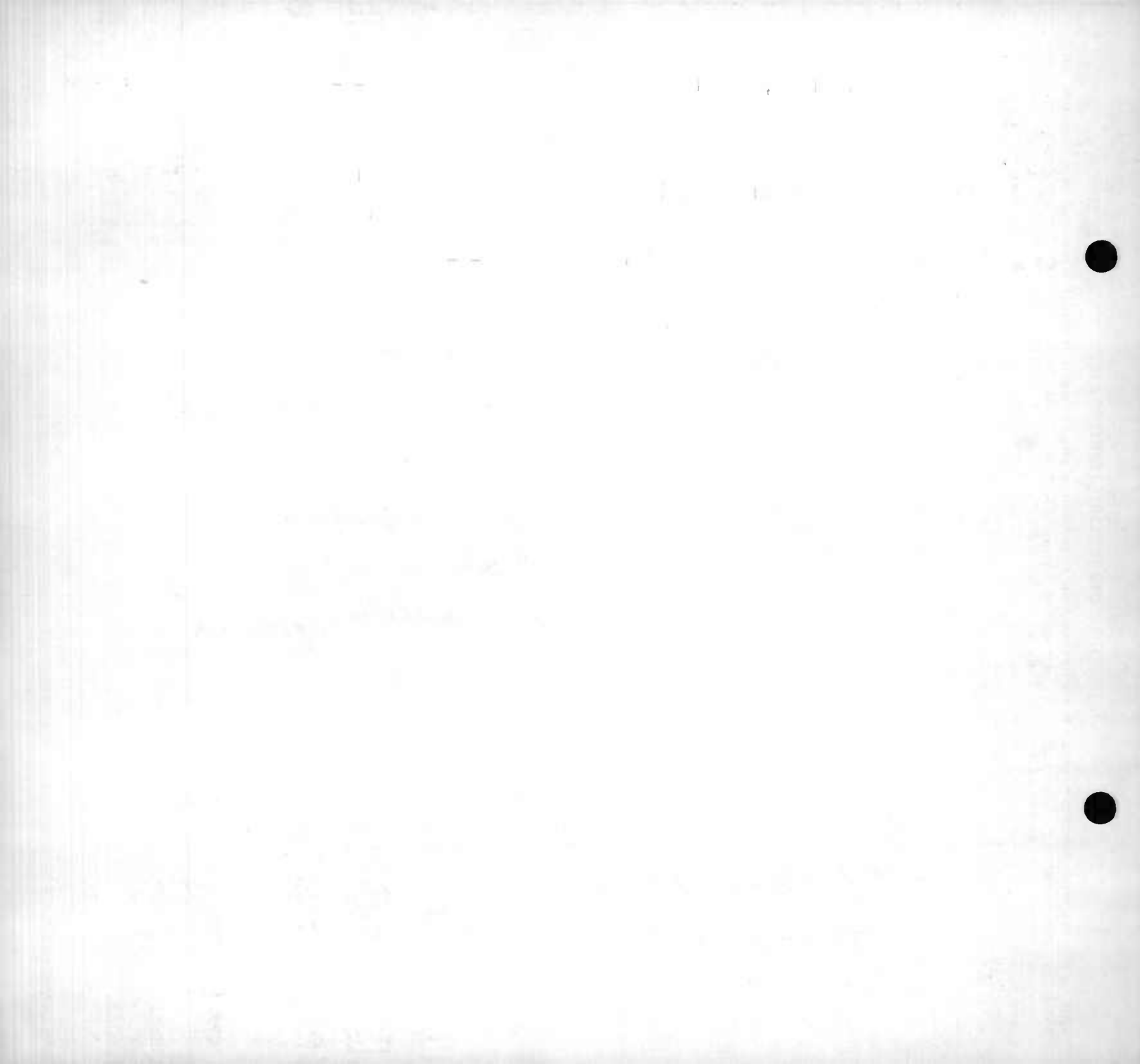
BIRTH NO. 66 06869		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06869	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) HELEN DAN DRIDGE		June 30, 1966 4:30 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 16-05 D. STREET ADDRESS (If rural, give location) 2533 W. Lanvale St.			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-12-93	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Robertson			14. MOTHER'S MAIDEN NAME Maggie Robertson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Polnor Dandridge - 4217 Kennison		
18. 174X+1 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Coma, Uremia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Metastases Ca of Uterus		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus Vesico-vaginal Fistula					
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPT? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natally medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 27, 1966 to June 30, 1966 , that (I) (we) last saw the deceased alive on June 30, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Desideria T. Mahusay M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6-30-66	
23C. PHYSICIAN'S NAME (Type) DESIDERIA T. MAHUSAY		23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-4-66	24C. NAME OF CEMETERY or CREMATORY Carver Court	24D. LOCATION (City, town, or county) (State) Lanval Mel		
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966	25B. NAME OF REGISTRAR Robert E. Jackson	25C. FUNERAL DIRECTOR ADDRESS Choyl Wilson 1000 Brantly Rd			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

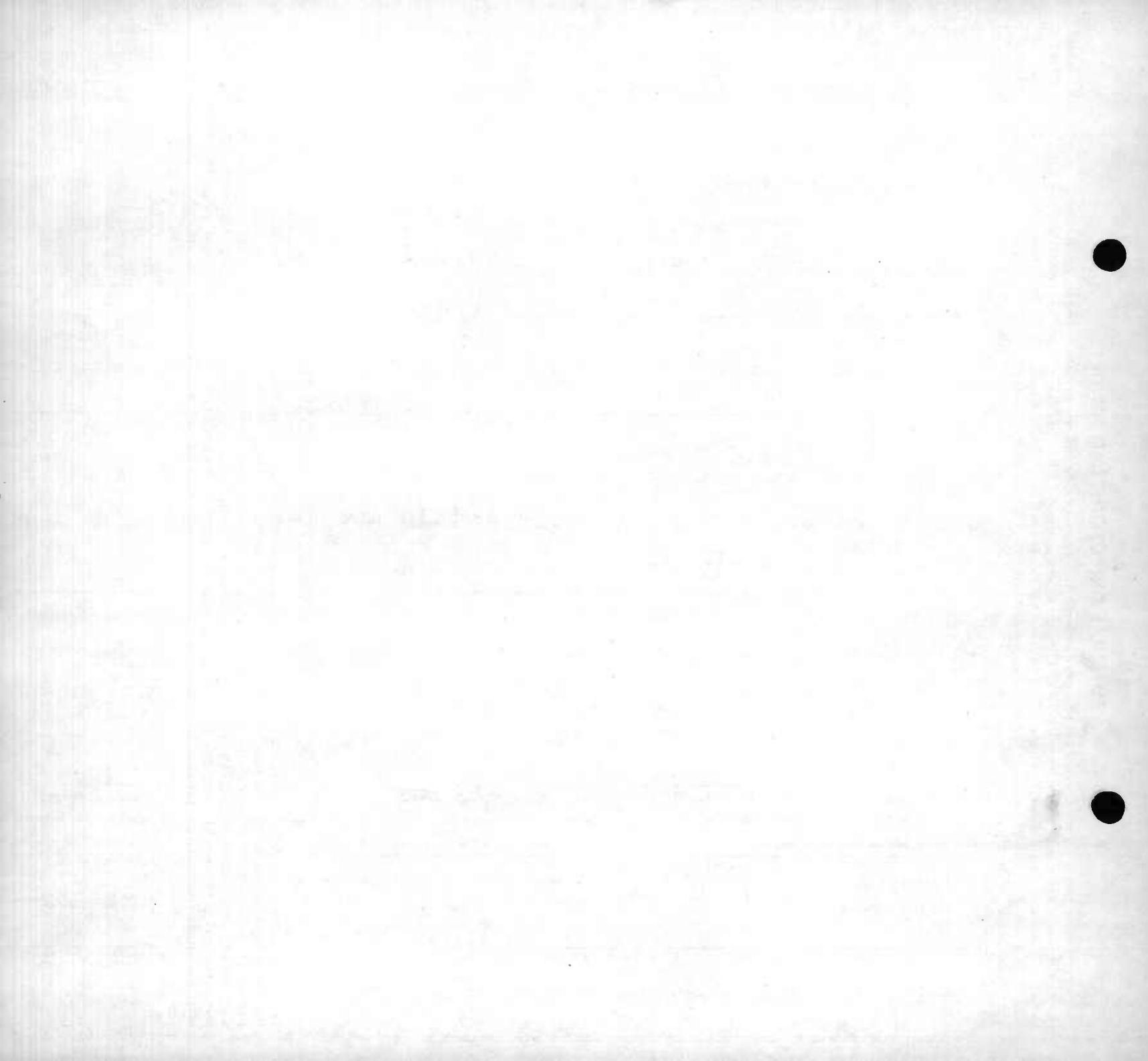
BALTIMORE CITY HEALTH DEPARTMENT										
66 06870					66 06870					
BIRTH NO.					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH					
WILLIAMS, NELLIE					7-4-66 4:05 AM M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY					
THE JOHNS HOPKINS HOSPITAL					MARYLAND					
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)					
GLEN BURNIE					330 ORDINANCE ROAD					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		
F		NEGRO		MARRIED		8-2-04		61		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife						A. Munchel Co. Md.		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
GEORGE BROOKS					FRANCES					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No							Mehum H Williams Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					
4-20-01-260X					CVA					
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO					
ANTECEDENT CAUSES					(B) ASHD in failure					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) None					
II					Diabetes mellitus, Pneumonia					
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)					White At <input type="checkbox"/> Work		Med. Director <input type="checkbox"/> At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from June 7 1966 to July 4 1966, that (1) (we) last saw the deceased alive on 2 AM July 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.										
23A. SIGNATURE					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED		
Tah-Hsiung Hsu								July 4 '66		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
TAH-Hsiung Hsu					The Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)			
Burial		7-7-66		Mt Calvary Cat.			Brooklyn Md			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS				
JUL 7 1966			Robert E. Farley			Cheryl Wilson Baltimore				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 06871					CERTIFICATE OF DEATH				
Registered No. 66 06871									
1. NAME OF DECEASED (Type or Print) Lucille Fosque					2. DATE AND HOUR OF DEATH July 3, 1966 12¹⁰ PM.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore, Inc.					A. STATE Maryland B. COUNTY Baltimore				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 2342 W. Fayette St.				
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6/12/25	9. AGE (In years last birthday) 41	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sonce Savage					14. MOTHER'S MAIDEN NAME Clarie Savage				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO.		17. INFORMANT Clarie Savage		ADDRESS Same		
18. 175.0 I					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)					(A) Pulmonary Embolism, suspected DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					(B) Metastatic Carcinoma of Ovary DUE TO				
					(C)				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 6/23/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory Laparotomy		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (H) (this hospital) attended the deceased from 6/3/65 to 7/3/66 , that (H) (we) last saw the deceased alive on 7/3/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (not) view the body after death.									
23A. SIGNATURE Allan S. Rudolph					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 3, 1966		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D. Sinai Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-66		24C. NAME of CEMETERY or CREMATORY Mt Airy Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1966		25B. NAME OF REGISTRAR A. E. Fink		25C. FUNERAL DIRECTOR ADDRESS Cheryl Wilson 1000 Broomfield					



J-520

66 06872

BALTIMORE CITY HEALTH DEPARTMENT

66 06872

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM JONES

2. DATE AND HOUR PRONOUNCED DEAD

July 1, 1966 1:45 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

802 W. Ostend Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

802 W. Ostend Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

March 4 - 1893

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Jesse Jones

14. MOTHER'S MAIDEN NAME

Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Ethel Jones

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-1-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-5-66

23C. NAME of CEMETERY or CREMATORY

Mt Antone Cem

23D. LOCATION (City, town, or county)

Balto Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1966

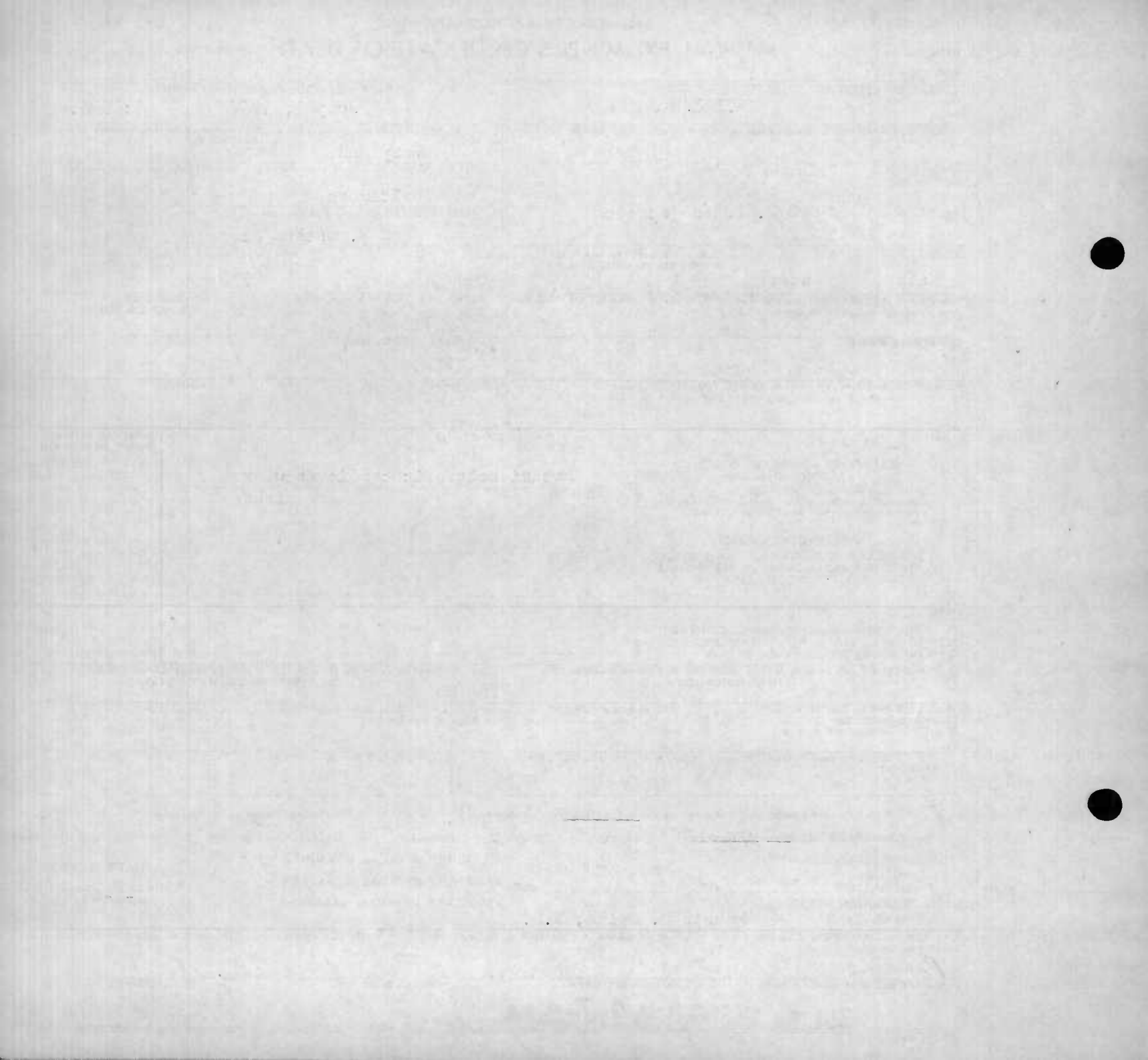
24B. NAME OF REGISTRAR

A. E. F. F. F.

24C. FUNERAL DIRECTOR

Choy C. Wilson 1000 B. B. B.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 06873					CERTIFICATE OF DEATH					Registered No. 66 06873				
1. NAME OF DECEASED (Type or Print) Marion W. Hubbard					2. DATE AND HOUR OF DEATH July 2, 1966 5³⁰ A. M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore					C. CITY OR TOWN (If outside city limits, write RURAL and give township) 10-01				
17. FATHER'S NAME Tom Hubbard					14. MOTHER'S MAIDEN NAME Sara Ann Biggallow					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.					17. INFORMANT Ehner Scott				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.0 I Anteriosclerosis					CAUSE OF DEATH (A) DUE TO Anteriosclerosis (B) DUE TO Anteriosclerosis (C) ?					INTERVAL BETWEEN ONSET AND DEATH 14 mos.				
19. DATE OF OPERATION										20. AUTOPSY? (Yes or No) no				
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)										22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
23. PHYSICIAN'S NAME (Type) F. K. ADAMS										24. ADDRESS 1222 N. Caroline St Baltimore Md.				
25. DATE REC'D BY HEALTH DEPT. JUL 7 1966										26. NAME OF REGISTRAR Robert E. Jenkins				
27. FUNERAL DIRECTOR Chas. S. Wilson										ADDRESS 1000 Brantley Ave.				

W. J. G.

May 10, 1954
Project, U.S.
Green Ann. Higgins
Cham Scott

Active & retired
Household
Household

W. J. G.

May 10, 1954
Project, U.S.
Green Ann. Higgins
Cham Scott

Active & retired
Household
Household

Patient of Dr. Royston Brown
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06874	
BIRTH NO. 66 06874		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Fab Blacklock		2. DATE AND HOUR OF DEATH July 5, 1966 7:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Home - 1513 N. Eden St.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1513 N. Eden St.			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH May 15, 1891	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Elliot Blacklock		14. MOTHER'S MAIDEN NAME Bertha	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Quincy Blacklock	
				ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.1 I		CAUSE OF DEATH (A) Arteriosclerosis Cordis - vascular disease (B) Due to (C) Due to		INTERVAL BETWEEN ONSET AND DEATH unknown	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 64 to June 19 66 , that (I) (we) last saw the deceased alive on May 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Royston B. Scott		M.D. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 6, 66	
23C. PHYSICIAN'S NAME (Type) ROYSTON B. SCOTT		23D. ADDRESS 18014 Baltimore St			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-66		24C. NAME OF CEMETERY or CREMATORY Carver Mem. Park	
24D. LOCATION (City, town, or county) (State) Laurel, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Elroy O. Wilson	
				ADDRESS 1000 Pratt Bldg	

Received of the
Estate of John
D. Smith
the sum of \$100.00
for the year 1911

Witness my hand and seal
this 1st day of January
1912

John D. Smith
Secretary

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <u>66 06875</u>	
BIRTH NO. <u>66 06875</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ETHEL TAYLOR</u>	
2. DATE AND HOUR OF DEATH <u>7-4-66</u> <u>1</u> <u>7-40</u> P		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 JOHNS HOPKINS HOSPITAL</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>31</u> D. STREET ADDRESS (If rural, give location) <u>1518 MAY COURT</u>		5. SEX <u>FEMALE</u> 6. RACE <u>NEGRO</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			
8. DATE OF BIRTH <u>1-8-05</u> 9. AGE (In years last birthday) <u>61</u>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ALBERT BROWN</u>	
14. MOTHER'S MAIDEN NAME <u>BESSIE NICHOLSON</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Don Elzey</u> ADDRESS <u>Same</u>		18. <u>260 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarct</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. (B) <u>Arterio-sclerotic heart disease</u> years (C) <u>Diabetes mellitus</u> years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initial medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While <input type="checkbox"/> At Work Not While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/4</u> <u>1966</u> to <u>7/4</u> <u>1966</u> , that (I) (we) lost saw the deceased alive on <u>7/4</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harmon J. Eyre</u> M.D.		23B. DATE SIGNED <u>7/4/66</u>		23C. PHYSICIAN'S NAME (Type) <u>Harmon J. Eyre</u> M.D.	
23D. ADDRESS <u>550 No Broadway #600 Bldg</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>7-9-66</u> 24C. NAME OF CEMETERY or CREMATORY <u>Mt Antuan Cmt</u> 24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1966</u>		25B. NAME OF REGISTRAR <u>Choyl. Wilson</u>		25C. FUNERAL DIRECTOR <u>Wilson</u> ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		66 06876		66 06876	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Annice Petty</i>			2. DATE AND HOUR OF DEATH <i>June 27-1966</i> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home Hospital</i>			A. STATE <i>Maryland</i>		
(If not in hospital or institution, give street address or location) <i>120 A</i>			B. COUNTY <i>Baltimore</i>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			D. STREET ADDRESS (If rural, give location) <i>1407 E. Fayette St</i>		
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>March 1891</i>	9. AGE (In years last birthday) <i>75</i>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Norfolk Va</i>	
13. FATHER'S NAME <i>unknown</i>			14. MOTHER'S MAIDEN NAME <i>unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Elizabeth Jones - 1820 Canton Place</i>	
18. <i>120.1</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Courney Thrombosis</i>		<i>immediate</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Hypertension</i>			
		(C) <i>Arteriosclerosis</i>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Atherosclerosis</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/14/65</i> 19 to <i>3/14</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>3/14</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Albert L. LaForest</i>				23B. DATE SIGNED <i>6/30/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR ALBERT L. LAFOREST</i>				23D. ADDRESS <i>822 N. Bond St</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-30-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Int Oakway Cmt</i>	
24D. LOCATION (City, town, or county) <i>Brooklyn Md</i>		24E. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1966</i>		24F. NAME OF REGISTRAR <i>Robert E. Jenkins</i>	
24G. FUNERAL DIRECTOR <i>Choy Wilcox</i>		24H. ADDRESS <i>1000 Brandywine</i>			

1-11-11

100

BIRTH NO. 65-31235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 06877

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print) Melvin Durant 2. DATE AND HOUR PRONOUNCED DEAD
July 4, 1966 12:20 P.
M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

542 N. Pulaski Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

542 N. Pulaski Street

5. SEX

Male

6. RACE

Colored7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)never married

8. DATE OF BIRTH

12-21-19659. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Baby

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md12. CITIZEN OF
WHAT COUNTRY?USA

13. FATHER'S NAME

Cunningham Durant

14. MOTHER'S MAIDEN NAME

Leona Sawyer15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, never unknown. If yes, give war or dates of service)No16. SOCIAL
SECURITY NO.

17. INFORMANT

Leona Sawyer - 542 N. Pulaski St

ADDRESS

18. I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Interstitial pneumonitis (SDII)

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Purulent otitis media left

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Werner U. Spitz, M.D.CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 5, 196623A. BURIAL CREMATION,
REMOVAL (Specify)Burial

23B. DATE

7-7-66

23C. NAME of CEMETERY or CREMATORY

mt Auburn

23D. LOCATION

(City, town, or county)

Baltimore

(State)

md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 7 1966 Robert E. FarberLumley S. Eden - Balto. Md.

WALTER P. BENTLEY

W. P. Bentley

FUNERAL DIRECTOR: IMPORTANT

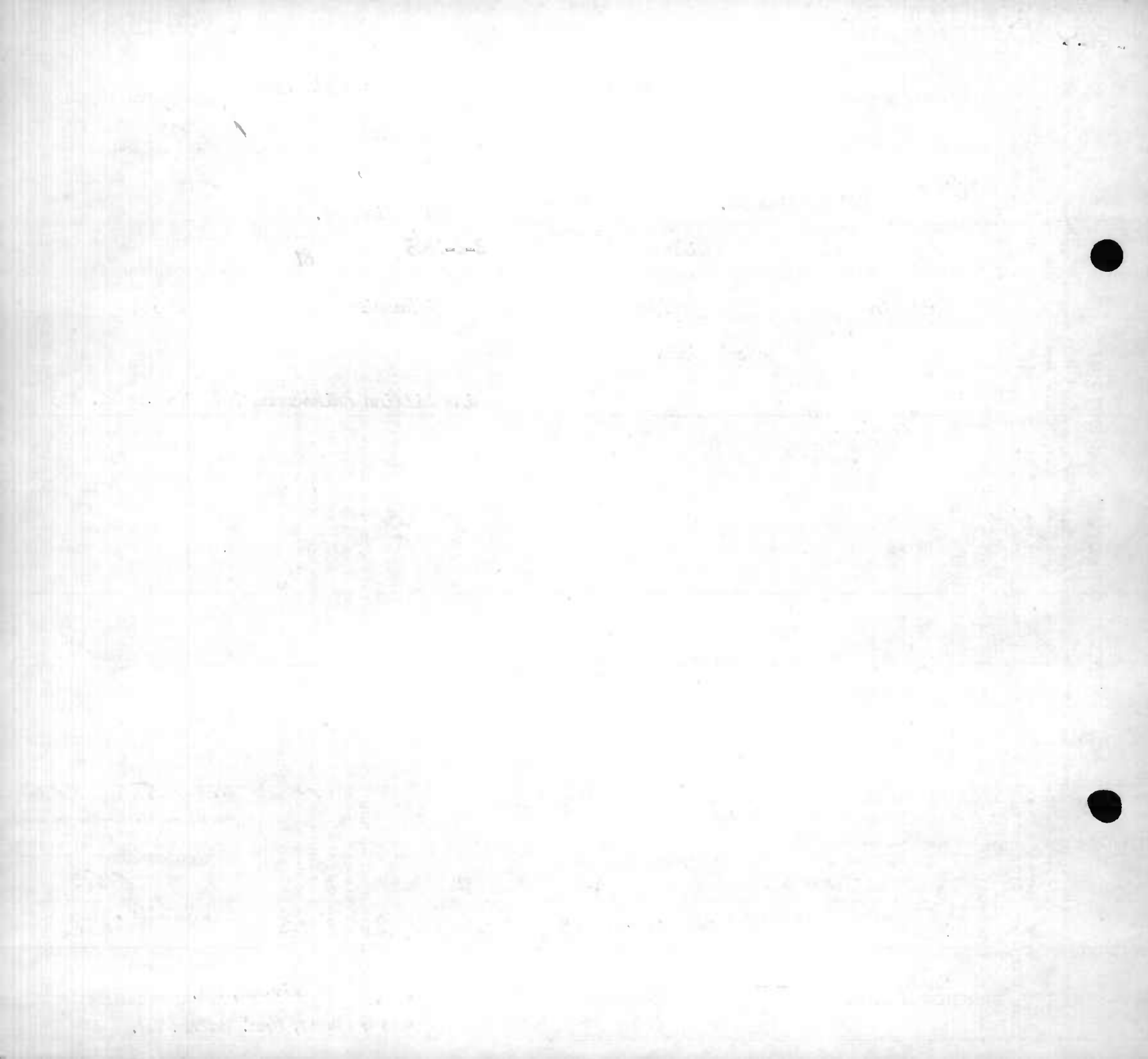
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 06878</u>	
BIRTH NO. <u>66 06878</u>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>ELIZA B. Brookin</u>				2. DATE AND HOUR OF DEATH <u>7-4-66</u> <u>4:30A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 LA PLAZA Nursing Home</u> <u>1515 Bruce ST</u>				A. STATE <u>Maryland</u>			
				C. CITY OR TOWN (If outside city limits, write "RURAL" and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>613 Lafayette Ave</u>			
5. SEX <u>Fe</u>	6. RACE <u>Col.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>9-12-1874</u>	9. AGE (In years last birthday) <u>91</u>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Lloyd Boyd</u>			14. MOTHER'S MAIDEN NAME <u>Lucy Thomas</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>MARY B. Queen - Wash. D.C.</u>				ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <u>420.1 I</u>			CAUSE OF DEATH (A) DUE TO <u>Coronary Thrombosis</u> (B) DUE TO <u>Generalized Sepsis</u> (C) DUE TO <u>Anterior Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6-3-66</u> 19 <u>66</u> to <u>7-4-</u> 19 <u>66</u> that (I) (we) lost saw the deceased alive on <u>7-4-</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Geo H Pendleton</u> M.D.				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Geo H Pendleton</u>	
23D. ADDRESS <u>1723 David Hall Ave Baltimore Md</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>7-7-66</u>				24C. NAME OF CEMETERY or CREMATORY <u>MT Auburn</u>			
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>				25A. DATE REC'D BY HEALTH DEPT. <u>66</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>				25C. FUNERAL DIRECTOR <u>Purnell S. Oden - BALTO. Md</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

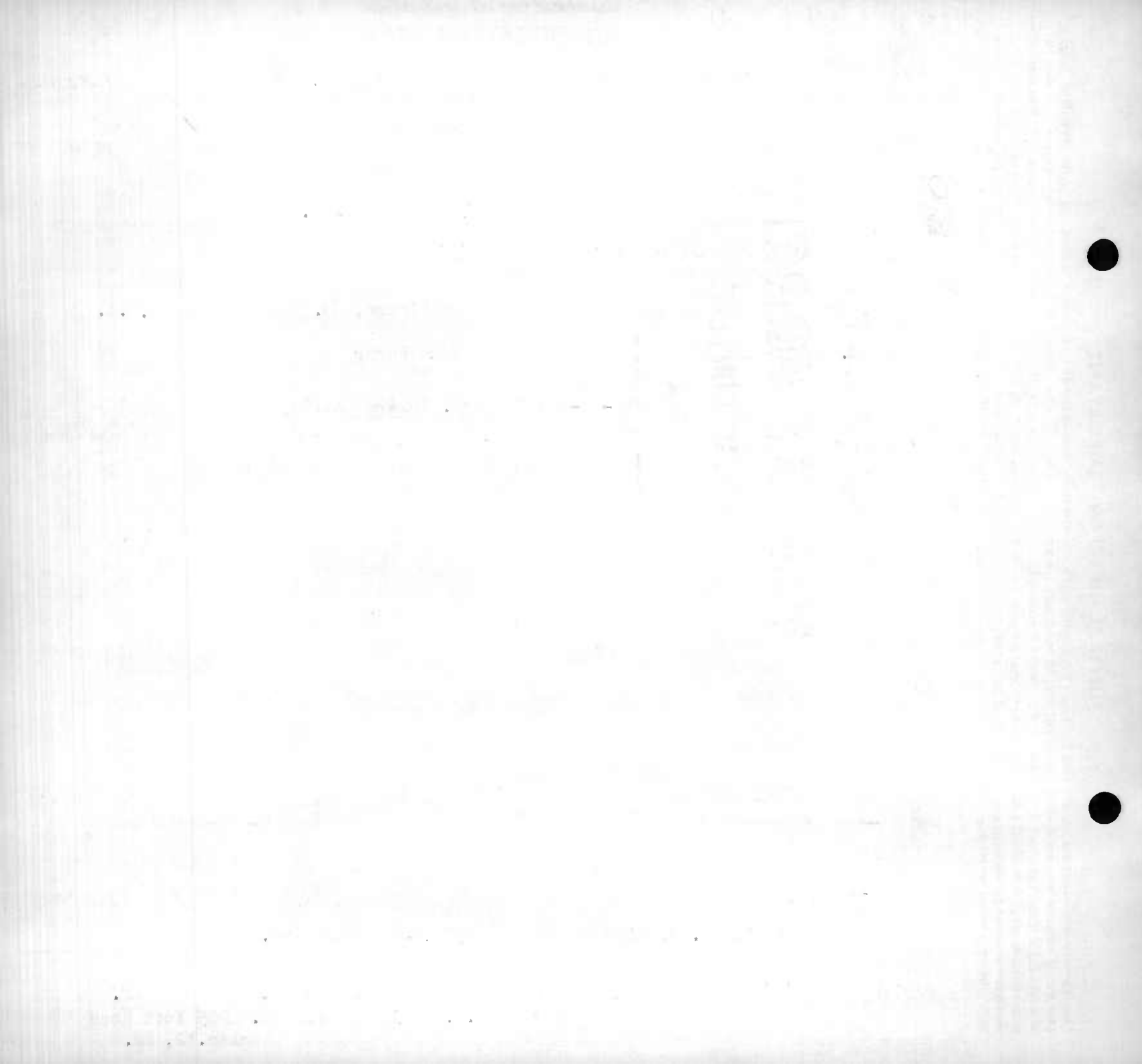
BIRTH NO. 66 06879		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06879	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Sally Pazukas		July 5th 1966			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(If not in hospital or institution, give street address or location)		Maryland		18-03	
823 Hollins St.		Baltimore,			
823 Hollins St.		D. STREET ADDRESS (If rural, give location)			
823 Hollins St.		823 Hollins St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.
Fem	wh	Widowed	2-2-1885	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Tailoring		Clothing		Lithuania	
12. CITIZEN OF WHAT COUNTRY?		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Joseph Rimas		Miss Lillian Krikscuras 1810 Spence St. # 3			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		no		Miss Lillian Krikscuras 1810 Spence St. # 3	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Coronary occlusion	
ANTECEDENT CAUSES		(B) DUE TO		Angina pectoris	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		A.S.C.D.	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		0		0	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
0		0		0	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
0		0		0	
22. I certify that (I) (this hospital) attended the deceased from 19 66 to July 5 19 66 , that (I) (we) last saw the deceased alive on July 5 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Stanley Ankus		7.6.66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
STANLEY ANKUS		1802 W. Boet Boet M/2ND3			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7-8-66		Most Holy Redeemer Cem	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 8 1966		Robert E. Farley		Thomas J Kenny, Inc. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

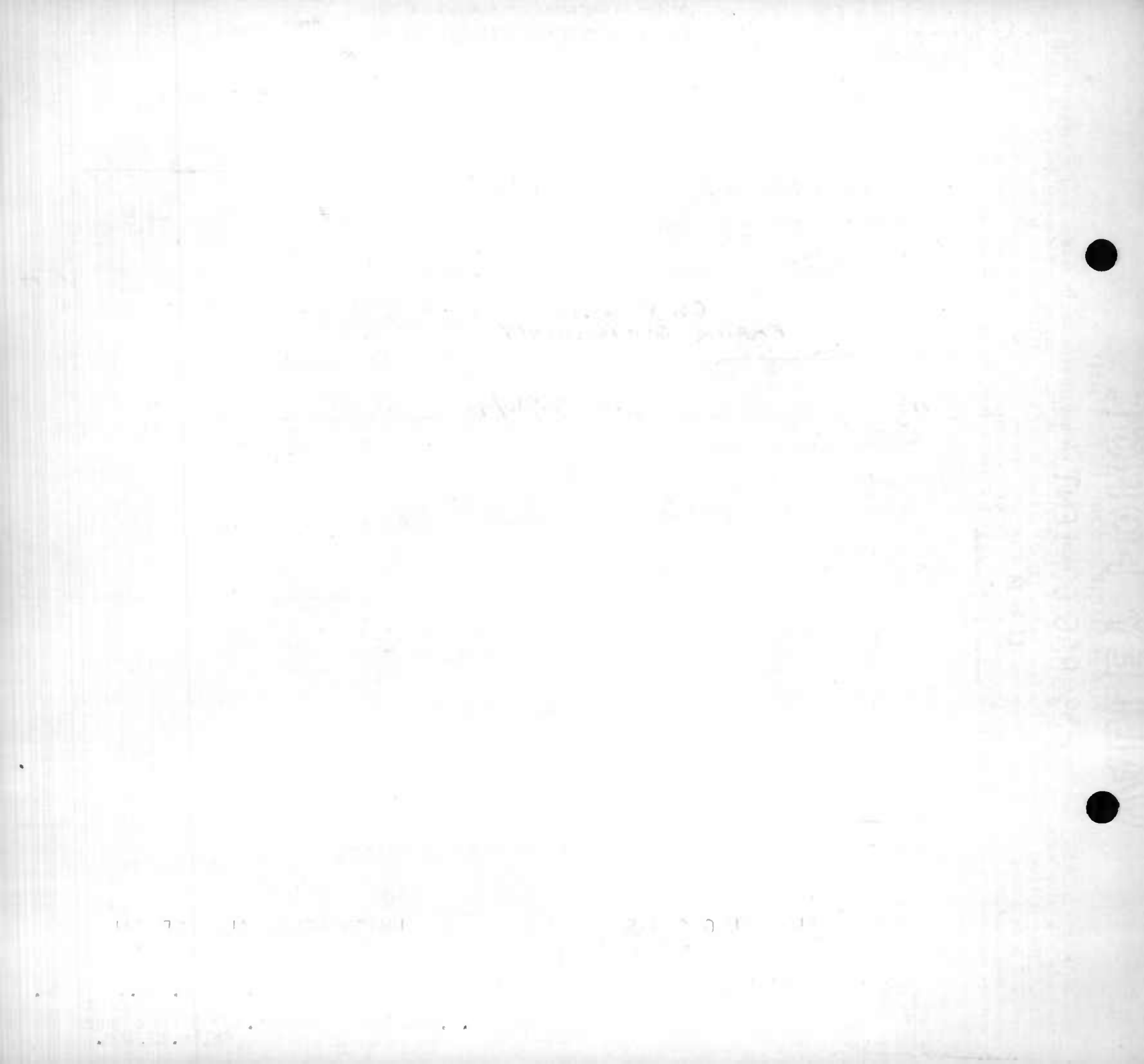
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06880	
BIRTH NO. 66 06880		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mazie Edna Robinson		July 4, 1966 11:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Hillcrest Nursing Home			A. STATE B. COUNTY Maryland 13-07		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 4146 Roland Ave.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 1/2/1901	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Harvey H. Robinson		14. MOTHER'S MAIDEN NAME Edna Baker		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-3 889		17. INFORMANT Mrs. Edward Mattingly	
				ADDRESS (Same)	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Arteriosclerotic. Cardio-Vascular Disease (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 28 1966 to July 4 1966, that (I) (we) last saw the deceased alive on July 4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William H. Fusting				23B. DATE SIGNED 7-7-66	
23C. PHYSICIAN'S NAME (Type) William H. Fusting				23D. ADDRESS 4230 Loch Raven Blvd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/1966		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Jenkins	
		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06881</u>
BIRTH NO. <u>66 06881</u>		CERTIFICATE OF DEATH		
M.E. CASE NO. <u>32-08-76 A2 E0</u>				
1. NAME OF DECEASED (Type or Print) <u>HICKMAN, ANNA ELIZABETH</u>		2. DATE AND HOUR OF DEATH <u>July 6, 1966, 1:35 PM</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hospital</u> (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
		D. STREET ADDRESS (If rural, give location) <u>5607 MCKEAN BLVD.</u>		
5. SEX <u>Female</u>	6. RACE (White) <u>AMERICAN</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED</u> (specify)	8. DATE OF BIRTH <u>06/20/84</u>	9. AGE (In years last birthday) <u>82</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA. AMERICAN</u>
13. FATHER'S NAME <u>FRANK GUNTERMANN</u>		14. MOTHER'S MAIDEN NAME <u>MARY MUELLER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-7309-B</u>		17. INFORMANT <u>U.M.H admission history</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>331X I</u> <u>vascular cerebral accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>Aspirational pneumonia 20</u>		<u>SC</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4:30 PM July 6, 1966</u> to <u>1:35 AM July 6, 1966</u> , that (I) (we) last saw the deceased alive on <u>1:30 AM July 6, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Sun Young Choi</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <u>SUN YOUNG CHOIS</u>		23D. ADDRESS <u>Union Memorial Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/9/1966</u>	24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park</u>	24D. LOCATION (City, town, or county) (State) <u>Parkville, Balto. Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>	25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

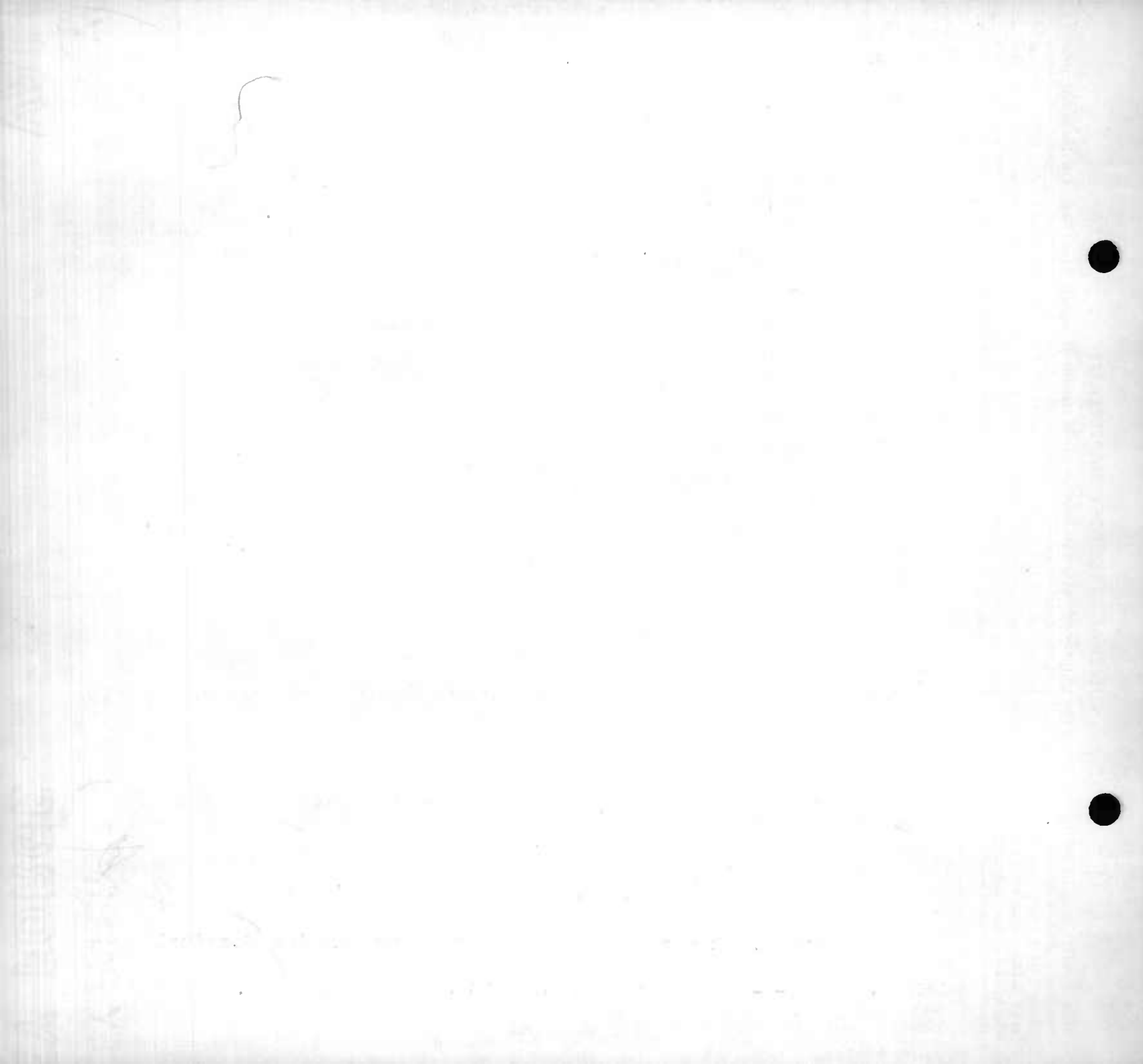
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06882	
BIRTH NO. 66 06882		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 7-6-66 4:55 P.M.	
1. NAME OF DECEASED (Type or Print) ANITA C. STANTON			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12	
		D. STREET ADDRESS (If rural, give location) 71 MURDOCK ROAD	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 9-17-04
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE	9. AGE (In years last birthday) 61
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN T. STANTON		14. MOTHER'S MAIDEN NAME ANNE MULANEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS MISS HELEN LUTMAN (SAME)
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES		(A) DUE TO Massive Upper GI bleeding terminal etiology unknown	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO poss of malignancy	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) _____	
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Parkinson's Dis.	20A. AUTOPSY? (Yes or No) no
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME OF INJURY (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____
22. I certify that (1) (this hospital) attended the deceased from July 2, 1966 to July 6, 1966 , that (1) (we) last saw the deceased alive on July 6, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Joseph M. France, Jr.		23B. DATE SIGNED July 6, 1966	
23C. PHYSICIAN'S NAME (Type) JOSEPH MARTIN FRANCE, JR.		23D. ADDRESS 301 E. St. Paul St. 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/8/1966	24C. NAME OF CEMETERY or CREMATORY New Cathedral	24D. LOCATION (City, town, or county) (State) Baltimore Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Farley	
		25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>120 168839</u>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <u>66-06883</u></p> <p>M.E. CASE NO. <u>66-11460</u></p> </div> <div style="text-align: center;"> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> </div> </div>					
1. NAME OF DECEASED (Type or Print) <u>MAYNOR Baby Boy</u>			2. DATE AND HOUR OF DEATH <u>7/3/66</u> <u>2:30 PM</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>10-01</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE, 2</u>		
			D. STREET ADDRESS (If rural, give location) <u>708 MURA ST.</u>		
5. SEX <u>MALE</u>	6. RACE <u>COLORED</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>INFANT</u>	8. DATE OF BIRTH <u>6-8-66</u>	9. AGE (In years last birthday) <u>1 MONTH</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOSEPH MCLEAN</u>			14. MOTHER'S MAIDEN NAME <u>GEORGUANNA MAYNOR</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <u>760.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>CARDIORESPIRATORY ARREST</u> DUE TO (B) <u>INTRACRANIAL BLEEDING & SPASTIC CEREBRAL PALSY</u> DUE TO (C) <u>PROBABLE BIRTH INJURY</u>		
			INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>2</u>				<u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>X</u> (this hospital) attended the deceased from <u>6/8</u> 19 <u>66</u> to <u>7/3</u> 19 <u>66</u> , that <u>X</u> (we) last saw the deceased alive on <u>7/3</u> 19 <u>66</u> and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>not</u> view the body after death.					
23A. SIGNATURE <u>Susan D. Stumbaugh</u> M.D.				23B. DATE SIGNED <u>7/3/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Susan D. Stumbaugh</u> M.D.				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>7-6-66</u>		24C. NAME of CEMETERY or CREMATORY <u>JOHNS HOPKINS HOSPITAL</u>	
				24D. LOCATION (City, town, or county) (State) <u>BA:TIMORE. MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06884		CERTIFICATE OF DEATH		Registered No. 66 06884	
1. NAME OF DECEASED (Type or Print) STEVENS, EARL, HENRY				2. DATE AND HOUR OF DEATH 7-3-66 12:45 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21228 D. STREET ADDRESS (If rural, give location) 315 SHADYNOOK AVE.					
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 5-16-95		9. AGE (In years last birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - SALES				10B. KIND OF BUSINESS OR INDUSTRY DAIRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM A.				14. MOTHER'S MAIDEN NAME KIZZIAH HODGES					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 220-09-6462		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS CATON & WILKENS AVE. 21229			
18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) MESENTERIC LYMPHOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. multiple metastasis				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6-30 19 66 to 7-3- 19 66 , that (I) (we) last saw the deceased alive on 7-3 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Rafael Marin				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/3/66			
23C. PHYSICIAN'S NAME (Type) RAFAEL MARIN				23D. ADDRESS ST. AGNES HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-66		24C. NAME OF CEMETERY or CREMATORY Green Mount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE RECEIVED BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Farley Canavanough		ADDRESS Funeral Home			

RECEIVED, 2 JUL 1964

1-3-64

1 JUL 64

ST. AGNES HOSPITAL

1 JUL 64
11:30 AM

WILLIAM WHITE

1-3-64

U.S.A.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06885				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06885	
1. NAME OF DECEASED (Type or Print) Sr. Mary Alzbeta Julian Kocsicek				2. DATE AND HOUR OF DEATH June 29, 1966 3⁰⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 10-02			
FULL NAME OF HOSPITAL OR INSTITUTION Institute of Notre Dame		(If not in hospital or institution, give street address or location) 901 Aisquith Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 901 AISQUITH STREET	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 2-23-1890	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY Religious		11. BIRTHPLACE (State or foreign country) Hungaria Pozsony-szeleskoti		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Martinus Kocsisek				14. MOTHER'S MAIDEN NAME Elisabetha Stolar			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Sr. M. Stan. Kostka		ADDRESS 901 Aisquith Sreet	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. ASCVD				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Instantaneous	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct 22 19 65 to June 29 19 66 , that (I) (we) lost saw the deceased alive on June 29 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John J. Darrell				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-29-66	
23C. PHYSICIAN'S NAME (Type) John Darrell				23D. ADDRESS Randallstown, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 1, 1966		24C. NAME OF CEMETERY or CREMATORY SISTERS CEMETERY		24D. LOCATION (City, town, or county) (State) NOTCHCLIFF, GLEN ARM, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR RAYMOND J. CURRAN		ADDRESS 817 SCARLETT DR TOWSON, MARYLAND 21204	

Pacific

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06886	
BIRTH NO. 66 06886		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KALB SR. JOHN L. B		2. DATE AND HOUR OF DEATH JULY 6 1966 1:15 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL		A. STATE MD B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1228 VOGT AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-11-85	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machineist		10B. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME LOUIS		14. MOTHER'S MAIDEN NAME MARTHA Hommerbocker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-09-8013		17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE.	
18. 540.1		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Peritonitis generalised			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Perforated peptic ulcer			
		(C) Electrolyte imbalance.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 11 1966 to JULY 6 1966 that (I) (we) last saw the deceased alive on JULY 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Steve C. Papastephanou				23B. DATE SIGNED 7-6-66	
23C. PHYSICIAN'S NAME (Type) STEVE PAPASTEPHANOU		23D. ADDRESS M.D. CATON & WILKENS AVE. BALTIMORE MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/66		24C. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Towson, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Tarkenton	
		25C. FUNERAL DIRECTOR Ambrose Inc. 1328 Sulphur Sp. Rd.		ADDRESS	

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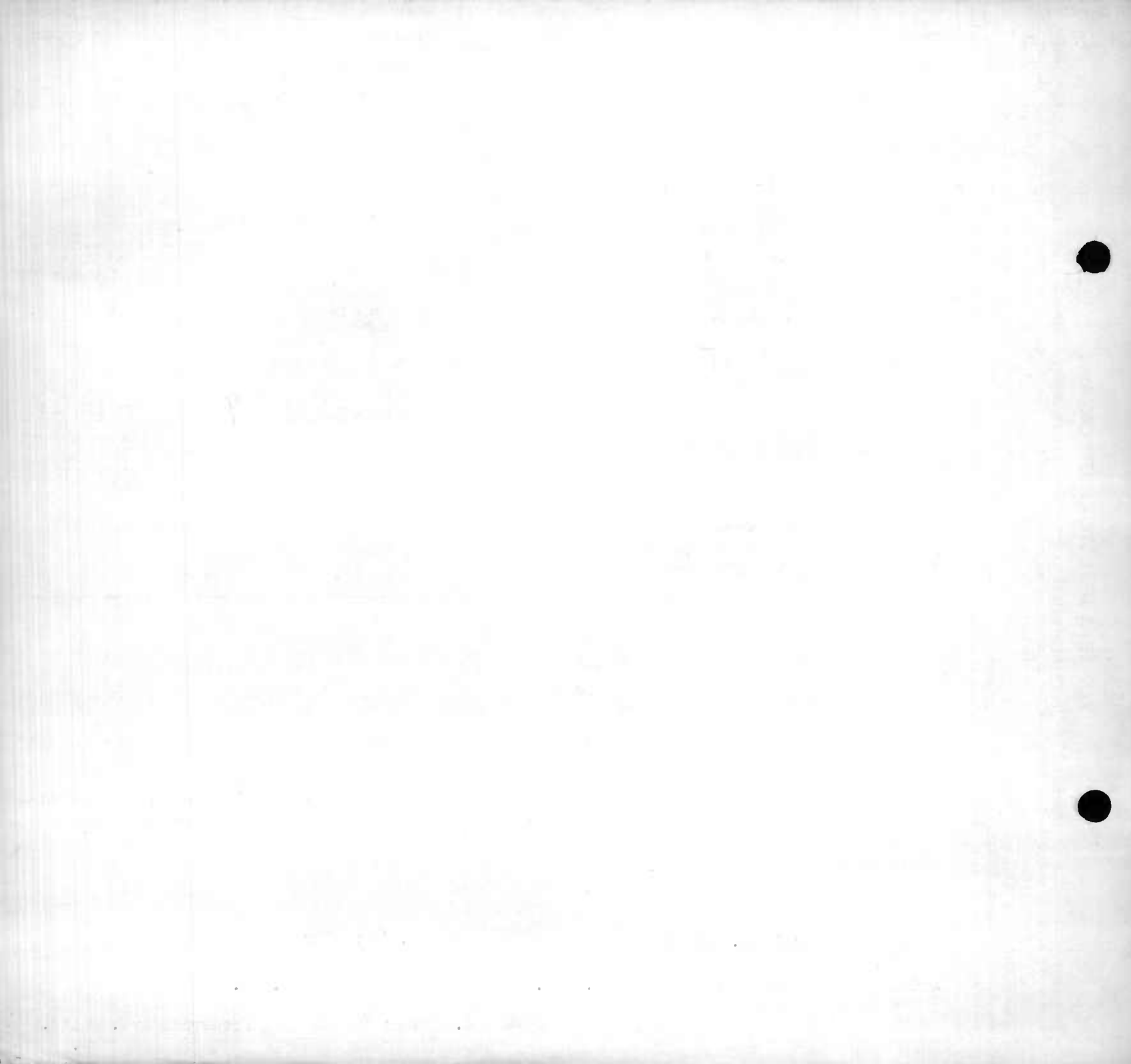
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06887</u>	
BIRTH NO. <u>66 06887</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Knight, Miss Bessie</u>		2. DATE AND HOUR OF DEATH <u>7-4-66</u> <u>7⁵⁰</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>"Kenswick", 700 W. 40th St.</u>		A. STATE <u>Maryland</u> 8. COUNTY <u>13-07</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>700 W. 40th St.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>Sept. 3, 1896</u>	9. AGE (In years last birthday) <u>89</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tel. operator - Standard</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John T. Knight</u>		14. MOTHER'S MAIDEN NAME <u>Laura V. Sands</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>H. Keller - R.N.; 700 W. 40th St.</u>	
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cerebral hemorrhage</u> DUE TO (B) <u>Generalized arteriosclerosis many yrs</u> DUE TO (C) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 19</u> 19 <u>57</u> to <u>July 4</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4 July 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harold P. Biehl</u> M.D.				23B. DATE SIGNED <u>5 July 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harold P. Biehl</u> M.D.				23D. ADDRESS <u>700 W. 40th Street</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 7, 1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Balto. Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Sisk</u>		25C. FUNERAL DIRECTOR ADDRESS <u>G. Truman Schwab 3512 Frederick Ave. Balto. Md.</u>			



66 06888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 06888

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Hugh Mc Glyn

2. DATE AND HOUR OF DEATH

6:22 PM 7/4/66

6:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Middle River

D. STREET ADDRESS (If rural, give location)

40 S. HAWTHORNE ROAD #21220 005

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

3-11-1897

9. AGE (In years
lost birthday)

69

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR INDUSTRY

Barber Shop

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN McGLYNN

14. MOTHER'S MAIDEN NAME

ELMIRIA MILLER

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL
SECURITY NO.

204 09 1446-RECORDS: BCH 4940 EASTERN AVE. #21224

17. INFORMANT

BALTIMORE, MD.

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH(A)
DUE TO

Myocardial Infarct

24 hours

(B)
DUE TO

Atherosclerosis

unknown

(C)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Emphysema

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/3/66 19 to 7/4/66 19
that (I) (we) lost saw the deceased alive on 7/4/66 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Wm. Emerson

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

July 4, 1966

23C. PHYSICIAN'S
NAME (Type)

WILLIAM EMERSON

M.D.

23D. ADDRESS

BALTIMORE CITY HOSPITALS #21224
4940 EASTERN AVENUE Balto., Md.24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/7/66

24C. NAME of CEMETERY or CREMATORY

Sacred Heart of Jesus Cemetery Baltimore Co., Md.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 8 1966

25B. NAME OF REGISTRAR

R. E. Farkas

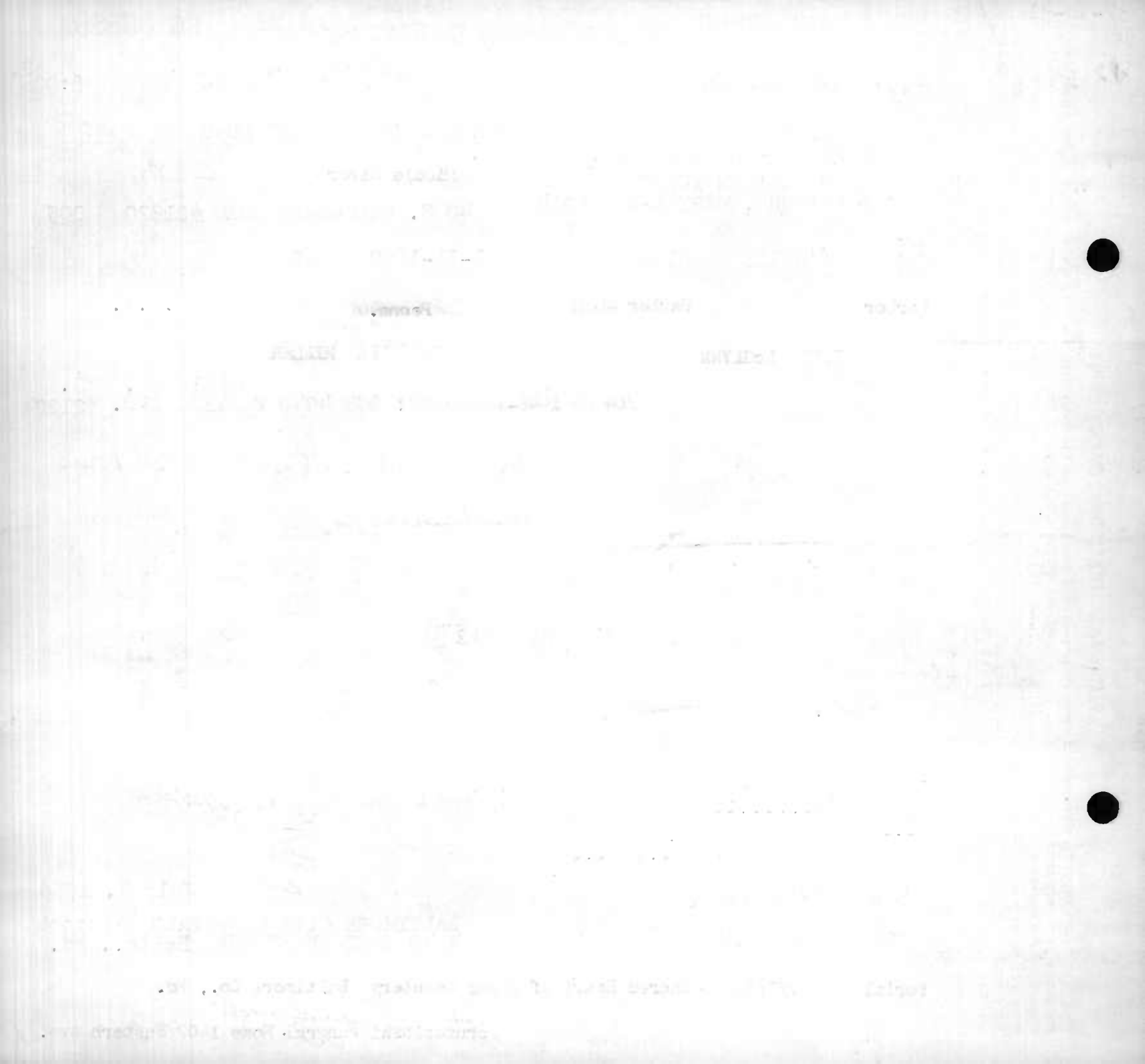
25C. FUNERAL DIRECTOR

Bruzdzinski Funeral Home 1407 Eastern Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		66 06889		Registered No. 66 06889	
BIRTH NO. 66 06889		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 7-4-66 6 ²⁰ P. M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FANNIE HILL		2. DATE AND HOUR OF DEATH 7-4-66 6 ²⁰ P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. AGE (In years last birthday) 84	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MELCHOR NURSING HOME		A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Sparrow Point (19)	
		D. STREET ADDRESS (If rural, give location) Box 14 Main St.		11. BIRTHPLACE (State or foreign country) Finland	
5. SEX F.	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 1, 1882	9. AGE (In years last birthday) 84	10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? Finland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --	
16. SOCIAL SECURITY NO. 213 07 3705		17. INFORMANT Cleveland Swain Kavander 3433 E 78th St Ohio 44127		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-14-1966 to 7-4-1966		22. I certify that (I) (we) lost saw the deceased alive on 7-4-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23B. DATE SIGNED 7-4-66	
23A. SIGNATURE Cesar Valle Cervera M.D.		23C. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO M.D.		23D. ADDRESS 8624 Liberty Rd. Randallstown	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7/6/66		24C. NAME of CEMETERY or CREMATORY Heslop Funeral Home	
24D. LOCATION Martins Ferry, Ohio		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Fink	
25C. FUNERAL DIRECTOR Bruzdinski		25D. ADDRESS Bruzdinski Funeral Home 1407 Eastern Ave.			

relatively

operation time (s)

box 1 - 10 min

June 1, 1942

50

10 min

Home

domestic

Training

Unknown

Unknown

to

233 07 3702

Swain November 24/53

233 07 3702

from up to 10 min

to 10 min

to 10 min

to 10 min

to 10 min

to 10 min

to 10 min

to 10 min

to 10 min

to 10 min

to 10 min

to 10 min

to 10 min

to 10 min

to 10 min

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06890		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06890	
M.E. CASE NO. (ROZAHIA)		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Rose A. Jankowiak		2. DATE AND HOUR OF DEATH July 6 1966 6 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		A. STATE MARYLAND B. COUNTY BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 8358 PHILADELPHIA ROAD 8358 OLD PHILADELPHIA ROAD 1010			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH AUG. 24-1894	9. AGE (in years last birthday) 71	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME VINCENT MAKOWIECKI		14. MOTHER'S MAIDEN NAME ANASTASIA ECKWERT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-07-3467		17. INFORMANT ADDRESS 8358 OLD PHILADELPHIA Rd. MRS. FLORENCE FAJKOWSKI-	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Acute Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/5 1966 to 7/6 1966, that (I) (we) last saw the deceased alive on 7/6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W Stan Wilson		M.D. Attending Phys. Med. Director Stiff Phys. X		23B. DATE SIGNED 7/6/66	
23C. PHYSICIAN'S NAME (Type) W Stan Wilson		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/11/66		24C. NAME OF CEMETERY or CHURCH ST. STANISLAUS	
24D. LOCATION (City, town, or county) 1300 DUNDALK AVE BALTO MD		24E. NAME OF REGISTRAR Robert E. Jankowiak		24F. FUNERAL DIRECTOR George A. Weber	
25A. DATE REC'D BY HEALTH DEPT 7/6/66		25B. NAME OF REGISTRAR		25C. ADDRESS 705 S ABBIN ST	

110

H

7/10/92 21 JAN 1992 1300Z HAWAIIAN ISLANDS
31-11-92 21 JAN 1992 1300Z HAWAIIAN ISLANDS

1
S-640

66 06891

BALTIMORE CITY HEALTH DEPARTMENT

66 06891

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROLAND SORRELL

2. DATE AND HOUR PRONOUNCED DEAD

7-6-66

3:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2728 Edmondson Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Child

8. DATE OF BIRTH

August 26, 1954

9. AGE (In years
last birthday)

11

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

School

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Richard Sorrell

14. MOTHER'S MAIDEN NAME

Lillian

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Chart

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)(A) Severe 2nd and 3rd degree burns
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Electrocutation
DUE TO

(C)

MEDICAL CERTIFICATION

ii

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)Pennsylvania
R. R. Yard21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?Pennsylvania R.R. Yard at
Edmondson Avenue Bridge21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 2 '66 12:15 PM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Struck by electrical
wires on box car

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-6-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/9/66

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 8 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Adolphu Halstead 1206 W North Ave

ADDRESS

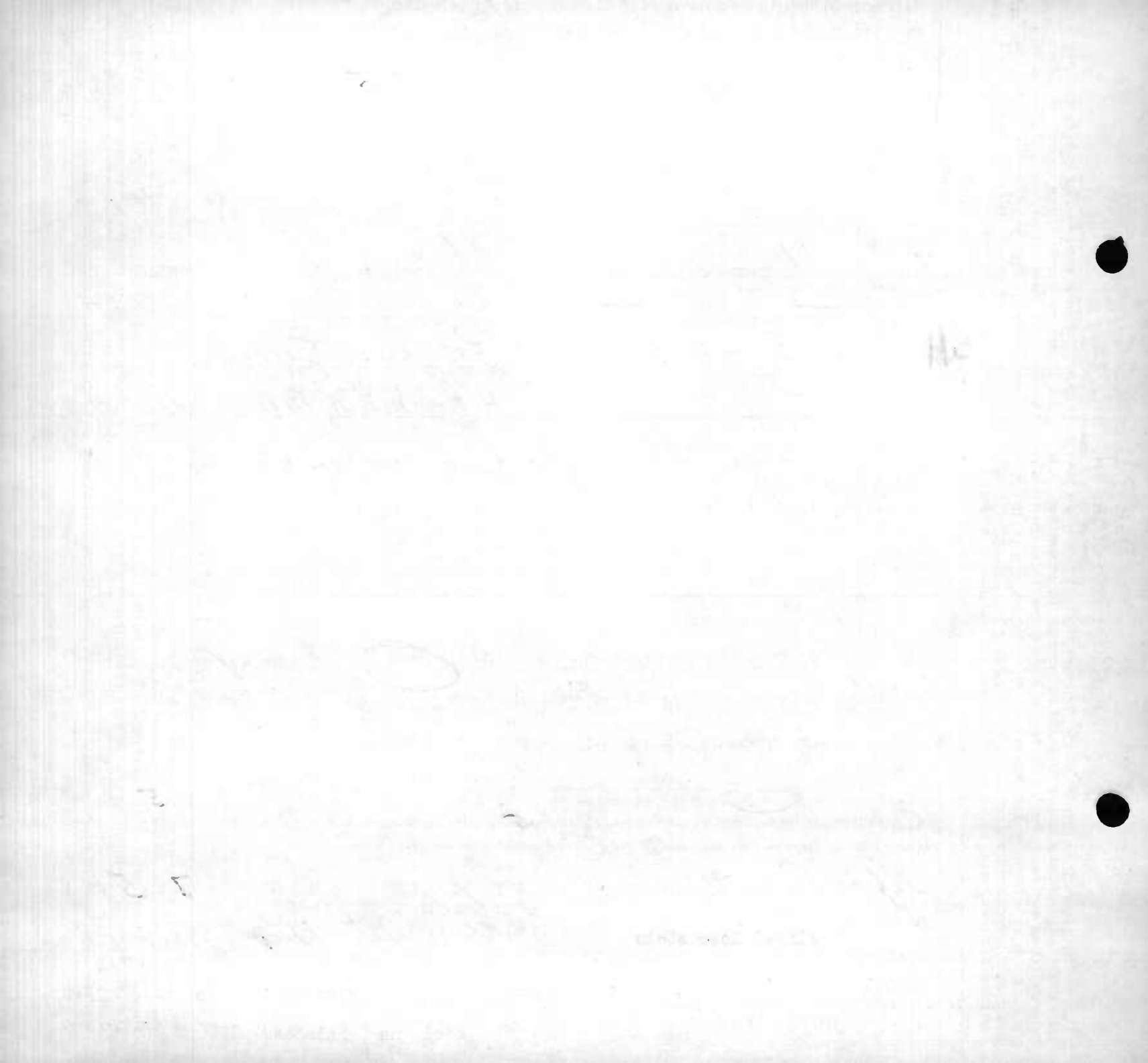
WALLER FORGE

MADE IN U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>Ohio</u> <u>66 06892</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 06892</u>	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>J. Leslie Russell</u>			<u>7/5/66</u> <u>18:30</u> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>			A. STATE <u>Md.</u> B. COUNTY <u>1702</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
			D. STREET ADDRESS (If rural, give location) <u>1531 N. Brant St. #17</u>		
5. SEX <u>7</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>9/12/14</u>	9. AGE (In years lost birthday) <u>1 3/4</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Shedrick Brookins</u>			14. MOTHER'S MAIDEN NAME <u>Patricia Russell</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>A. Rosenstein, M.D.</u>		ADDRESS <u>Univ. Hosp</u>
18. <u>75415 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Congenital Heart Disease</u> DUE TO <u>? S.B.E.</u> (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <u>birth</u> <u>2 days</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2 0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/29</u> 19 <u>66</u> to <u>7/5</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/5</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alfred Rosenstein</u>				23B. DATE SIGNED <u>7/5/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alfred Rosenstein</u>				23D. ADDRESS <u>University Hosp; Dept of Ped.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/10/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Warsaw Cemetery</u>	
24D. LOCATION <u>Cincinnati Ohio</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>		ADDRESS <u>1206 W North Ave</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06893				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06893	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) GILBERT E. TWILLEY		2. DATE AND HOUR OF DEATH 7/4/66		4:17AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-01		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 1815 EDMONDSON AVENUE 21228	
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE 29, MD.		(If not in hospital or institution, give street address or location)		5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAYMASTER		10B. KIND OF BUSINESS OR INDUSTRY B. & O. RAILROAD		8. DATE OF BIRTH 12-15-06		9. AGE (In years lost birthday) 59		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
13. FATHER'S NAME LEVIN TWILLEY				14. MOTHER'S MAIDEN NAME UNKNOWN DARBY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 705-03-4097		17. INFORMANT MRS. HELEN F. TWILLEY, 1815 EDMONDSON ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTERVAL BETWEEN ONSET AND DEATH				(A) DUE TO Acute Myocardial Infarction with					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) showing the UNDERLYING CONDITION last.				(B) DUE TO Acute Pulmonary Edema.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7/3 1966 to 7/4 1966, that (I) (we) last saw the deceased alive on 7/4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE DR. RAFAEL MARIN				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/4/66			
23C. PHYSICIAN'S NAME (Type) DR. RAFAEL MARIN				23D. ADDRESS 10 Spine Bldg.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-6-66		24C. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY		24D. LOCATION (City, town, or county) (State) ROANOKE, VIRGINIA			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVENUE					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06894		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06894	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 7/4/66 4:50 P.M.	
1. NAME OF DECEASED (Type or Print) JOHN WINTER		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE 8. COUNTY BALTO. MD			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER		10B. KIND OF BUSINESS OR INDUSTRY BETH. STEEL		11. BIRTHPLACE (State or foreign country) BALTO. Md	
13. FATHER'S NAME GEO. WINTER		14. MOTHER'S MAIDEN NAME CATHERINE SCHROEDER		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-055-251		17. INFORMANT WIFE	
18. I 165X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) PNEUMONIA		9 days	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(B) CARCINOMA of LUNG		4 yrs	
ANTECEDENT CAUSES		(C) METASTATIC LESION TO BRAIN		2 MONTHS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/25/1966 to 7/4/1966, that (I) (we) last saw the deceased alive on 7/4/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wm C. Lawling M.D.		23B. DATE, SIGNED 7/4/66		23C. PHYSICIAN'S NAME (Type) M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-1966		24C. NAME OF CEMETERY or CREMATORY Zion Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS (36) Lassahn Funeral Home 7401 Belair Road	

W. H. L.

MARYLAND GENERAL HOSPITAL

2/27/00

W

STREET WORKER

BETH-STEEL

BALTO. Md.

CATHERINE S. L. K. G. E. R.

Geo. W. White

No. 212-222 W. 1st

No.

Permanently

Preservation of health

Resistant to disease

100

2/27/00

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Wm. C. Young

X

Grandview General Hospital

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06895	
BIRTH NO. 66 06895		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Harrist Hattie Phillipson		2. DATE AND HOUR OF DEATH July 6, 1966 7:30 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Friedlers Guest House 2449 Shirley Avenue Baltimore, Maryland 21215		A. STATE Maryland B. COUNTY 15-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2449 Shirley Avenue 15			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 1/3/1876	9. AGE (In years last birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Julius Harry Flescher		14. MOTHER'S MAIDEN NAME Carrie Habel			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-24-1005		17. INFORMANT ADDRESS Julius Flescher 161 W. 75th St. N.Y.C.	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) C. V. A. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. H A S H D INTERVAL BETWEEN ONSET AND DEATH 1 day 19 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/1/66 to 7/6 19 66 , that (I) (we) last saw the deceased alive on 7/6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Zinberg		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/6/66	
23C. PHYSICIAN'S NAME (Type) Dr. Zinberg		23D. ADDRESS 4000 W. Northern Parkway			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/1966		24C. NAME of CEMETERY or CREMATORY Baltimore Hebrew	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Dr. E. E. F. F.		25C. FUNERAL DIRECTOR ADDRESS Jack Lewis, Inc 2100 Centre Pl	

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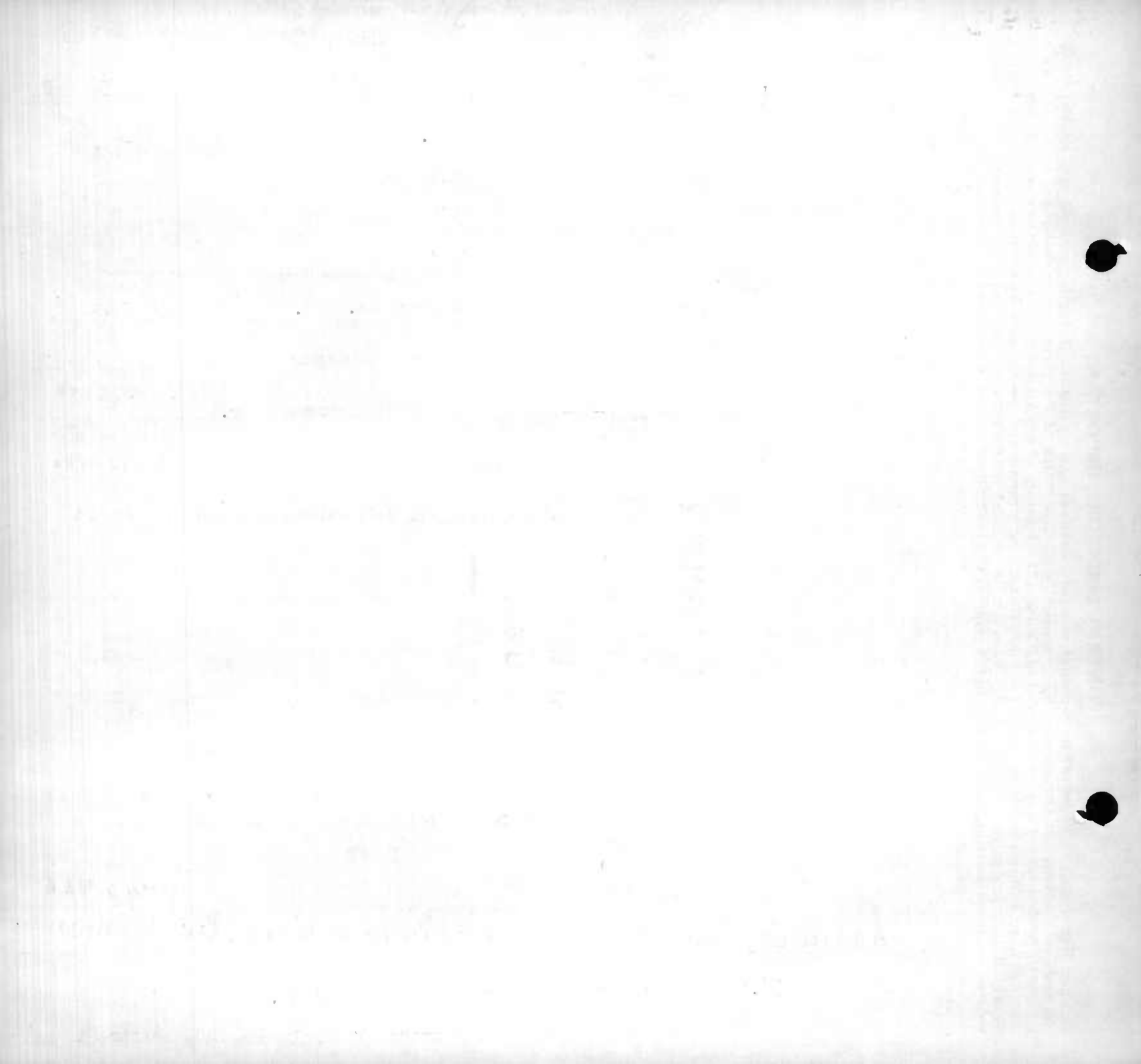
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06896</u>	
BIRTH NO. <u>66 06896</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Rosalie P Behrmann</u>		2. DATE AND HOUR OF DEATH <u>6/5/66</u> <u>3</u> <u>P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2601</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>4313 Raspe Ave</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>4313 Raspe Ave</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>2/21/1898</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOMEMAKER</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Krach</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Neubauer</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-7258</u>		17. INFORMANT <u>Harry R Behrmann Jr.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>422.1 I</u> CAUSE OF DEATH (A) <u>CARDIAC FAILURE</u> DUE TO (B) <u>ARTERIOCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> <u>10 YEARS</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>May 17</u> 19 <u>66</u> to <u>July 5</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 5</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Adam G. Swiss</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>July 6, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>ADAM G. SWISS</u>		23D. ADDRESS <u>6232 BELAIR ROAD, BALTO. MD 21206</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/8/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Mem Park</u>	
24D. LOCATION <u>Balto. Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1966</u>		24F. NAME OF REGISTRAR <u>Robert E. Farley</u>	
24G. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		24H. ADDRESS <u>7401 Belair Rd</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06897		CERTIFICATE OF DEATH		Registered No. 66 06897	
1. NAME OF DECEASED (Type or Print) <i>Catherine M. McKenna</i>				2. DATE AND HOUR OF DEATH <i>7/6/66 10 A. M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1315 W. Lombard St.</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>1903</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1315 W. Lombard St.</i>					
5. SEX <i>Female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>4/7/1885</i>		9. AGE (In years last birthday) <i>81</i>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Work</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Joseph McKenna</i>				14. MOTHER'S MAIDEN NAME <i>Mary McGuire</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>			16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mr Frank Blair</i>		ADDRESS <i>above</i>		
18. <i>4200 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Atherosclerotic Heart Disease</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>7-5-1966</i> to <i>7-6-1966</i> , that (I) (we) last saw the deceased alive on <i>7-5-66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Morris B. Schreiber</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED <i>7/7/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>MORRIS B. SCHREIBER</i>						23D. ADDRESS <i>1519 W. Lombard St. Baltimore Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/9/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>4300 Old Frederick Rd. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1966</i>		25B. NAME OF REGISTRAR <i>Paul E. Fink</i>		25C. FUNERAL DIRECTOR <i>John J. Lowman & Son</i>		ADDRESS <i>25, Md.</i>			

To Be Approved By Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06898		BALTIMORE CITY HEALTH DEPARTMENT		66 06898	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print)		PERKINS, WILLIAM SILUS		2. DATE AND HOUR OF DEATH 6-25-66 9:15 AM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (If not in hospital or institution, give street address or location) WILKENS & CATON AVE. BALTIMORE, MD.		A. STATE MARYLAND B. COUNTY Howard C. CITY OR TOWN (If outside city limits, write RURAL and give township) SAVAGE D. STREET ADDRESS (If rural, give location) 612 WASHINGTON STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6-26-79	9. AGE (in years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) fireman		10B. KIND OF BUSINESS OR INDUSTRY cotton duck mill		11. BIRTHPLACE (State or foreign county) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? YES		13. FATHER'S NAME JOHN Perkins		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215078974		17. INFORMANT WILKENS & CATON AVES ST. AGNES RECORDS-BALTO., MARYLAND	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. CAUSE OF DEATH Pulmonary Embolus Fractured Right Hip		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 612 Washington St.	
21D. TIME OF INJURY (APPROX.) 6 18 66 730 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fall out of doorway	
22. I certify that (X) (this hospital) attended the deceased from 6-18-66 19 to 6-25-66 19		that (X) (we) last saw the deceased alive on JUNE 25, 19 66		and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.	
23A. SIGNATURE R.J. Hollocker		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) R.J. HOLLOCKER, M.D.		23D. ADDRESS WILKENS & CATON AVES ST. AGNES HOSPITAL-BALTIMORE, MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-66		24C. NAME OF CEMETERY or CREMATORY Savage Cemetery	
24D. LOCATION (City, town, or county) (State) Savage Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR William H. Hoadley, Funeral Md.		25D. ADDRESS			

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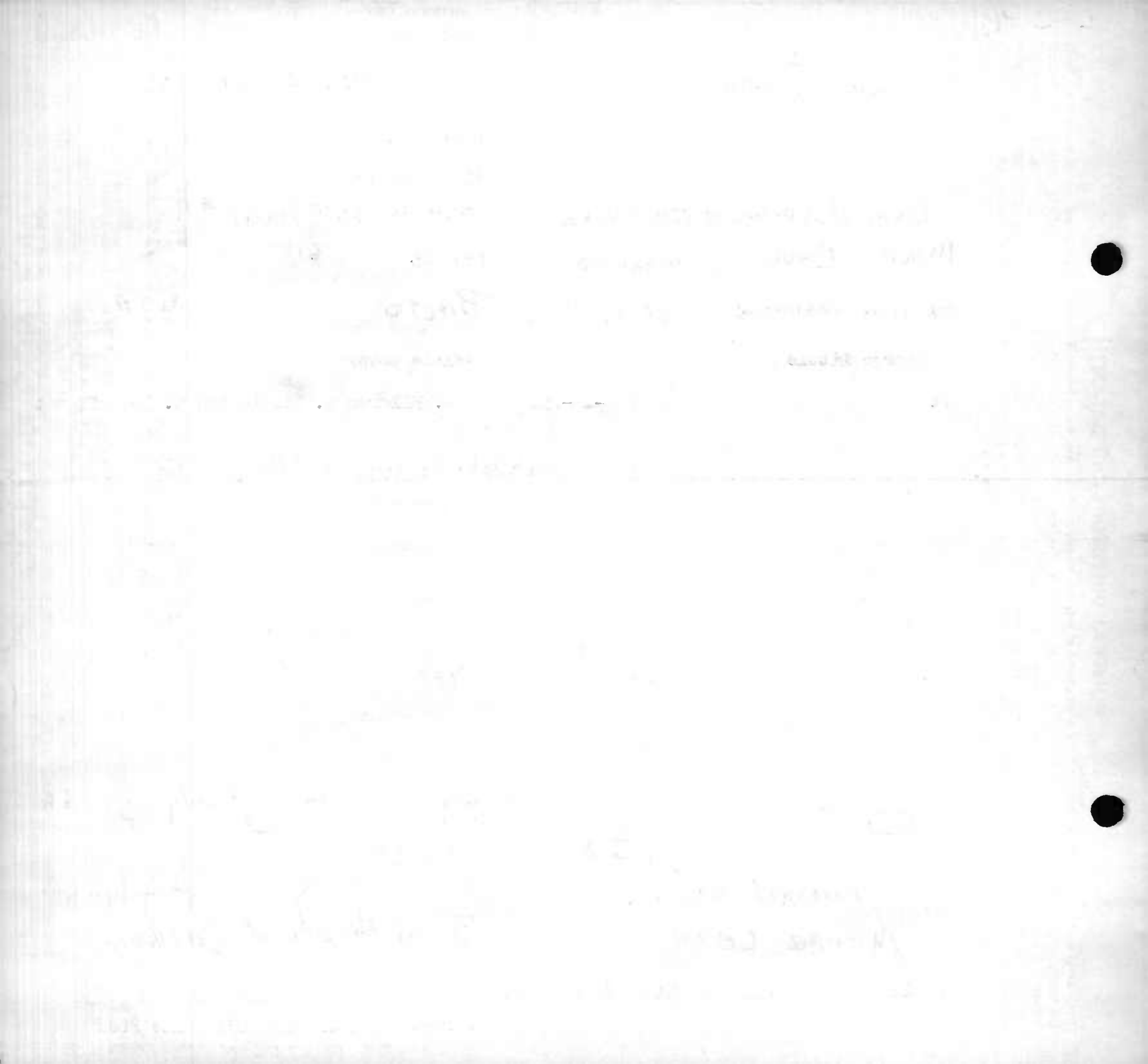
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

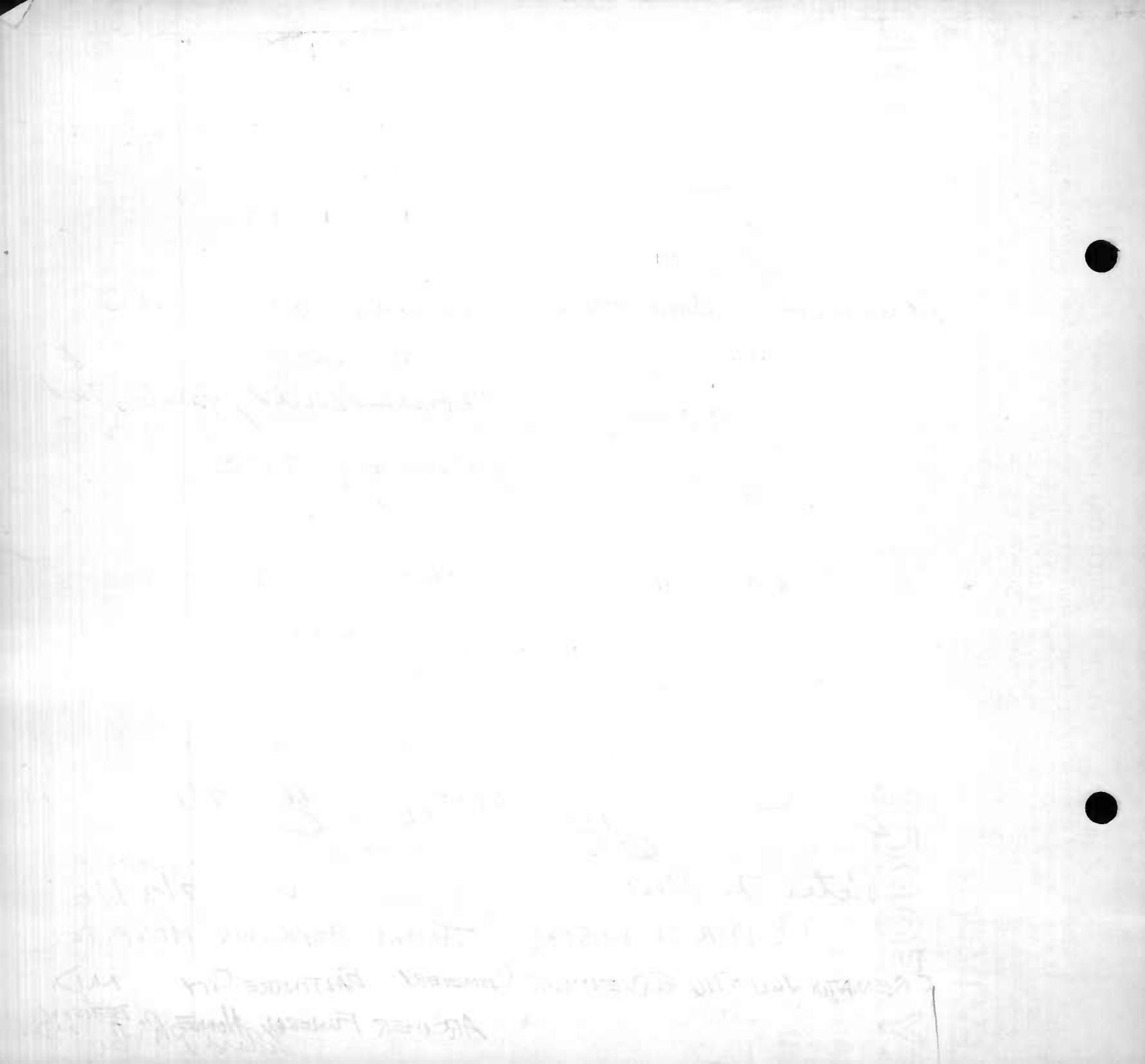
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06899		CERTIFICATE OF DEATH		Registered No. 66 06899	
1. NAME OF DECEASED (Type or Print) LEROY LITTLE				2. DATE AND HOUR OF DEATH 8:58 AM, 4 JULY '66 M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL of BALTIMORE				A. STATE MARYLAND		B. COUNTY 13-06			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
				D. STREET ADDRESS (If rural, give location) 804 W. 35th STREET #11					
5. SEX MALE	6. RACE CAUC	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 1-1-05	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR				10B. KIND OF BUSINESS OR INDUSTRY OFFICE Bldg.		11. BIRTHPLACE (State or foreign country) BALTO.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Little				14. MOTHER'S MAIDEN NAME Elsie Cover					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-10-0567		17. INFORMANT Mrs. Mildred C. Little, 804 W. 35th Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma of Lung				CAUSE OF DEATH (A) DUE TO Metastatic Carcinoma of Lung		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) DUE TO —		(C) DUE TO —			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —					
22. I certify that (1) (this hospital) attended the deceased from 3 July 1966 to 4 July 1966 , that (1) (we) last saw the deceased alive on 4 July 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Michael Levin				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4 July 66			
23C. PHYSICIAN'S NAME (Type) Michael Levin				23D. ADDRESS Sinai Hospital of Baltimore					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 July 66		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR Burgess Funeral Home 3631 Falls Road		ADDRESS Lynn Burgess Henson			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06900		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06900	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GUILD M.D. STACY R.		2. DATE AND HOUR OF DEATH 7/3/66 8:30 a M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE MARYLAND B. COUNTY HARFORD COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) FALLSTON		D. STREET ADDRESS (If rural, give location) FRIENDSHIP ROAD	
5. SEX M	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 8-22-90	9. AGE (In years last birthday) 75	II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scientist		10B. KIND OF BUSINESS OR INDUSTRY Anatomist		11. BIRTHPLACE (State or foreign country) Kansas Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME HARRY GUILD		14. MOTHER'S MAIDEN NAME MYRTLE JONES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Thomas Guild, Fallston, Md	
18. 002.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO pulmonary TBC			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Emphysema ASHD			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes for No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/20 19 66 to 7/3 19 66 , that (I) <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/3 19 66 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE Peter J. Rosen		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/3/66	
23C. PHYSICIAN'S NAME (Type) PETER J ROSEN		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE JULY 5 1966		24C. NAME OF CEMETERY or CREMATORY GREENMOUNT CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE CITY MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1966			
25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR ARCHER FUNERAL HOME			
25D. ADDRESS 1144 North ...		25E. SIGNATURE ...			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
66 06901					66 06901					
BIRTH NO.					CERTIFICATE OF DEATH					
M.E. CASE NO.					Registered No.					
1. NAME OF DECEASED (Type or Print) <u>Frederick W. Necker</u>					2. DATE AND HOUR OF DEATH <u>7/5/66</u> <u>4:50</u> P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Johns Hopkins Hospital</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>St. Michaels</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Rural</u> D. STREET ADDRESS (If rural, give location) <u>St. Michaels 70-00</u> <u>RFD #1</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>7-14-92</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOSEPH P. Necker</u>					14. MOTHER'S MAIDEN NAME <u>EMMA TRUMPER</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>					16. SOCIAL SECURITY NO. <u>216-07-6415</u>		17. INFORMANT <u>Charles - Hospital</u>			
18. <u>451X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Intestinal obstruction</u>					CAUSE OF DEATH (A) DUE TO <u>Intestinal obstruction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pneumonia</u>					(B) DUE TO <u>Ruptured abdominal</u>		(C) <u>aortic aneurysm</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <u>6/18 + 6/28/66</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ruptured aneurysm, Intest</u>			20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> 19 <u>66</u> to <u>7/5</u> 19 <u>66</u> , that (I) was last saw the deceased alive on <u>7/5</u> 19 <u>66</u> and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.										
23A. SIGNATURE <u>Fremont P. Wirth Jr.</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>7/5/66</u>		
23C. PHYSICIAN'S NAME (Type) <u>Fremont P. Wirth Jr.</u> M.D.					23D. ADDRESS <u>The Johns Hopkins Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>7-9-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>1966</u>			25B. NAME OF REGISTRAR <u>Robert E. Farley</u>			25C. FUNERAL DIRECTOR <u>Chas. F. Evans</u>			ADDRESS <u>8802 Highland Rd</u>	

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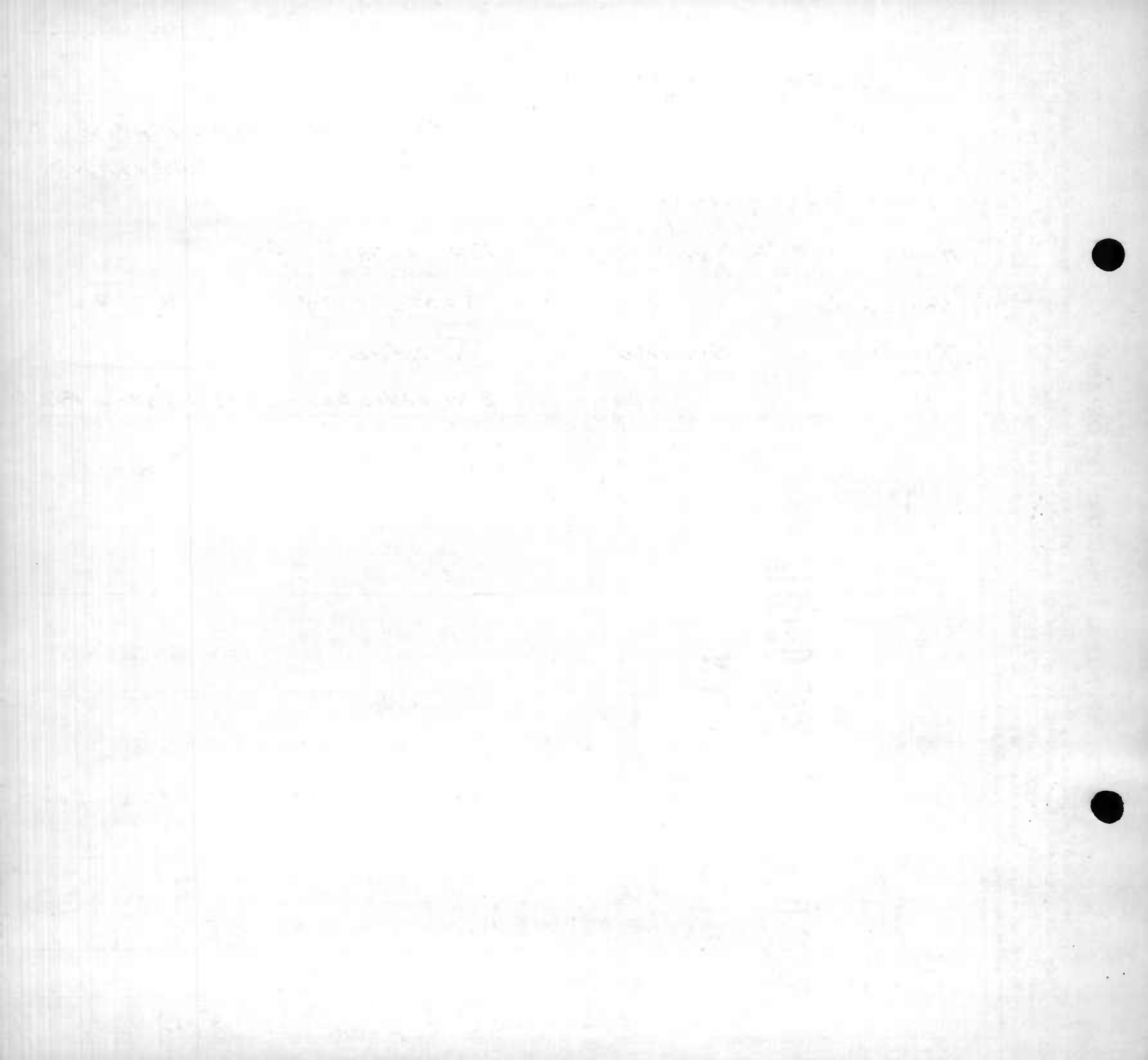
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06902		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06902	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) OLLAH L. HAXEL			7/5/66 1 750 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Pine Ridge Nursing Home			A. STATE MD B. COUNTY ST.		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MARYLAND		
			D. STREET ADDRESS (If rural, give location) 10-02		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH FEB-14-1881	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTO CITY		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME RICHARD SWANN		14. MOTHER'S MAIDEN NAME RACHAEL		?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-07-5966		17. INFORMANT SON ADDRESS E. W. DAVIS, SR. - 3519 ROYSTON AVE. 6	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ASCVD			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/10 1964 to 7/5 1966 , that (I) (we) last saw the deceased alive on 12/1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George H. Beck			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/5/66
23C. PHYSICIAN'S NAME (Type) GEORGE H. BECK			23D. ADDRESS 6012 HARFORD ROAD BALTO MD 21214		
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 7-8-66		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Balti		24E. (City, town, or county)		24F. (State) MD	
25A. DATE REC'D IN HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Tanenbaum		25C. FUNERAL DIRECTOR C. F. EVANS JR	
25D. ADDRESS		25E. ADDRESS 8802 Harford Rd			



FUNERAL DIRECTOR: IMPORTANT

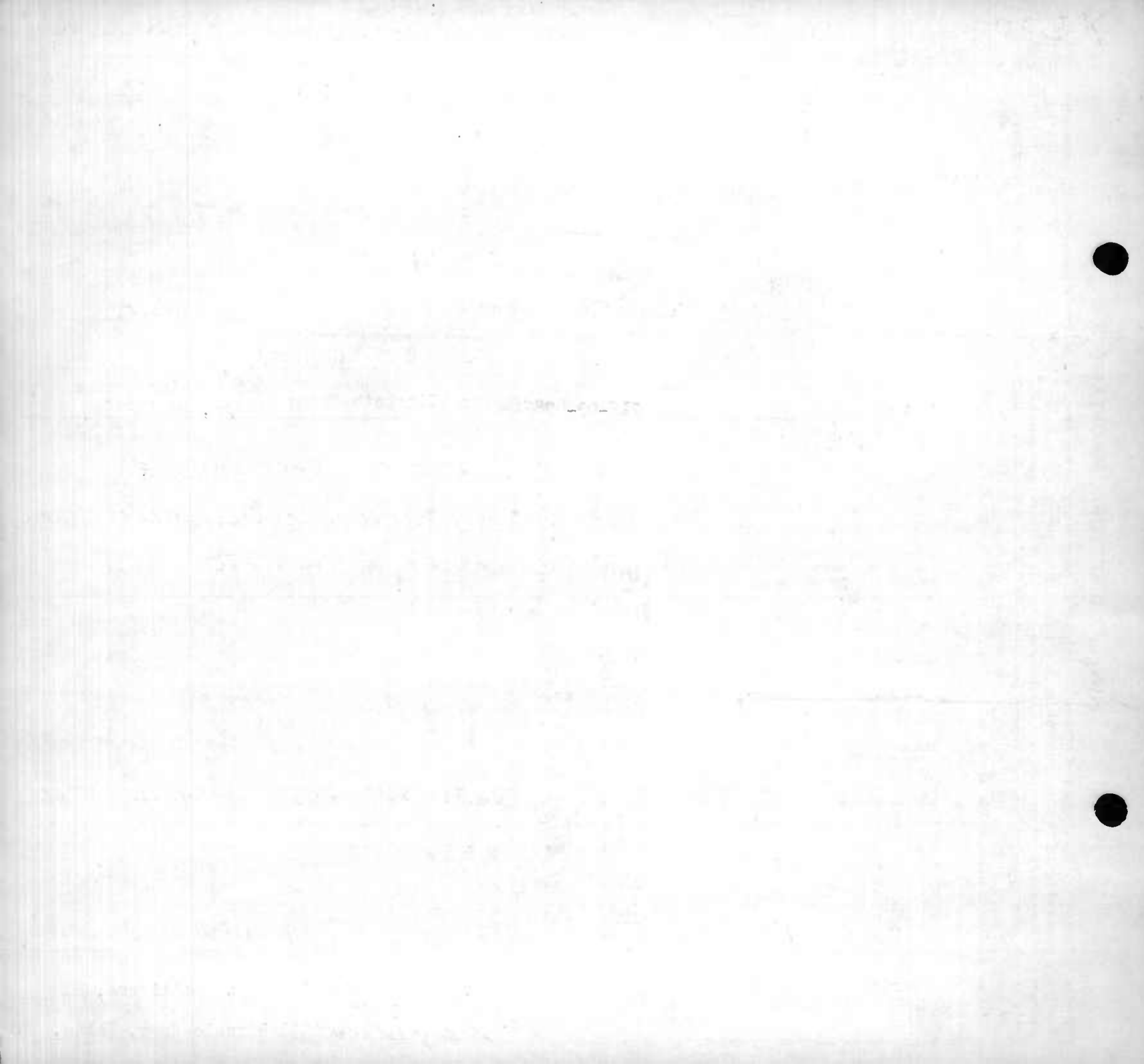
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06903	
BIRTH NO. 66 06903		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 7-6-66 4:30A M.	
1. NAME OF DECEASED (Type or Print) LEVY, ANNA C.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 25 52-00	
		D. STREET ADDRESS (If rural, give location) 5215 SIXTH STREET	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-6-85
		9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME FRANK TOMASEK	
14. MOTHER'S MAIDEN NAME ROSE BEDNAR		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 212260857		17. INFORMANT ADDRESS ST. AGNES RECORDS - CATON & WILKENS AVE	
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CVA (B) Hypertension + ASCVD (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 29 1966 to JULY 6 1966 , that (I) (we) last saw the deceased alive on JULY 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Cecil Gobal M.D.		23B. DATE SIGNED 7/6/66	
23C. PHYSICIAN'S NAME (Type) CECIL GOBAL M.D.		23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE July 9, 1966	24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery	24D. LOCATION (City, town, or county) (State) Ritchie Hwy. Balto. Md. 21225
25A. DATE RECEIVED BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy. 21225	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

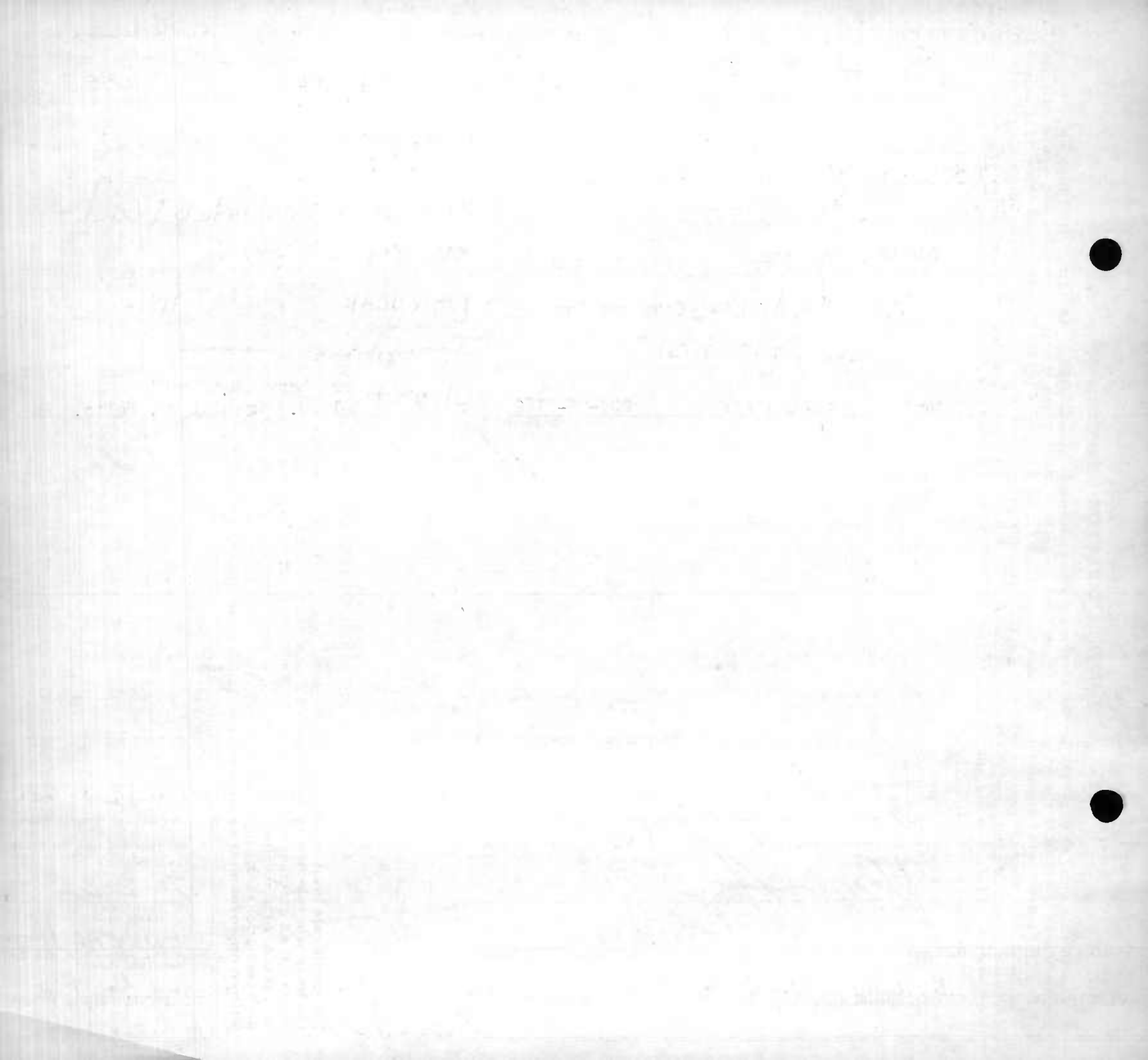
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 06904 <i>YOUNG</i>					CERTIFICATE OF DEATH			Registered No. 66 06904	
1. NAME OF DECEASED (Type or Print) <i>THOMAS YOUNG</i>					2. DATE AND HOUR OF DEATH <i>JULY 4, 1966</i> <i>6:15</i> A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>FRANKLIN SQUARE HOSPITAL</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>25-04</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>806 PONTIAC AVE.</i>				
5. SEX <i>MALE</i>	6. RACE <i>CAUCASIAN</i>	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>APRIL 21, 1893</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED (Mechanic)</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Linen Thread Company</i>		11. BIRTHPLACE (State or foreign country) <i>SCOTLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>WILLIAM YOUNG</i>					14. MOTHER'S MAIDEN NAME <i>JANET MILLER</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO Not stated</i>			16. SOCIAL SECURITY NO. <i>215-03-4985A</i>		17. INFORMANT <i>Mrs Elizabeth Young</i>		ADDRESS <i>806 Pontiac Avenue Balto, Md 21225</i>		
18. <i>422/1177X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>① CONGESTIVE HEART FAILURE</i> DUE TO (B) <i>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</i> DUE TO (C) <i>② CANCER OF PROSTATE</i>			INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>June 28</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>June 28</i> 19 <i>66</i> to <i>July 4</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>July 4</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>B. Neubaum</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>EMR NEUBAUER</i>					23D. ADDRESS M.D. <i>Franklin Sq. Hospital, Balto Md</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>JUL 87/7/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Ritchie Hgwy, Baltimore, Md</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>July 8 1966</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR ADDRESS <i>14001 Ritchie Hgwy, Balto, Md</i>			



FUNERAL DIRECTOR: IMPORTANT

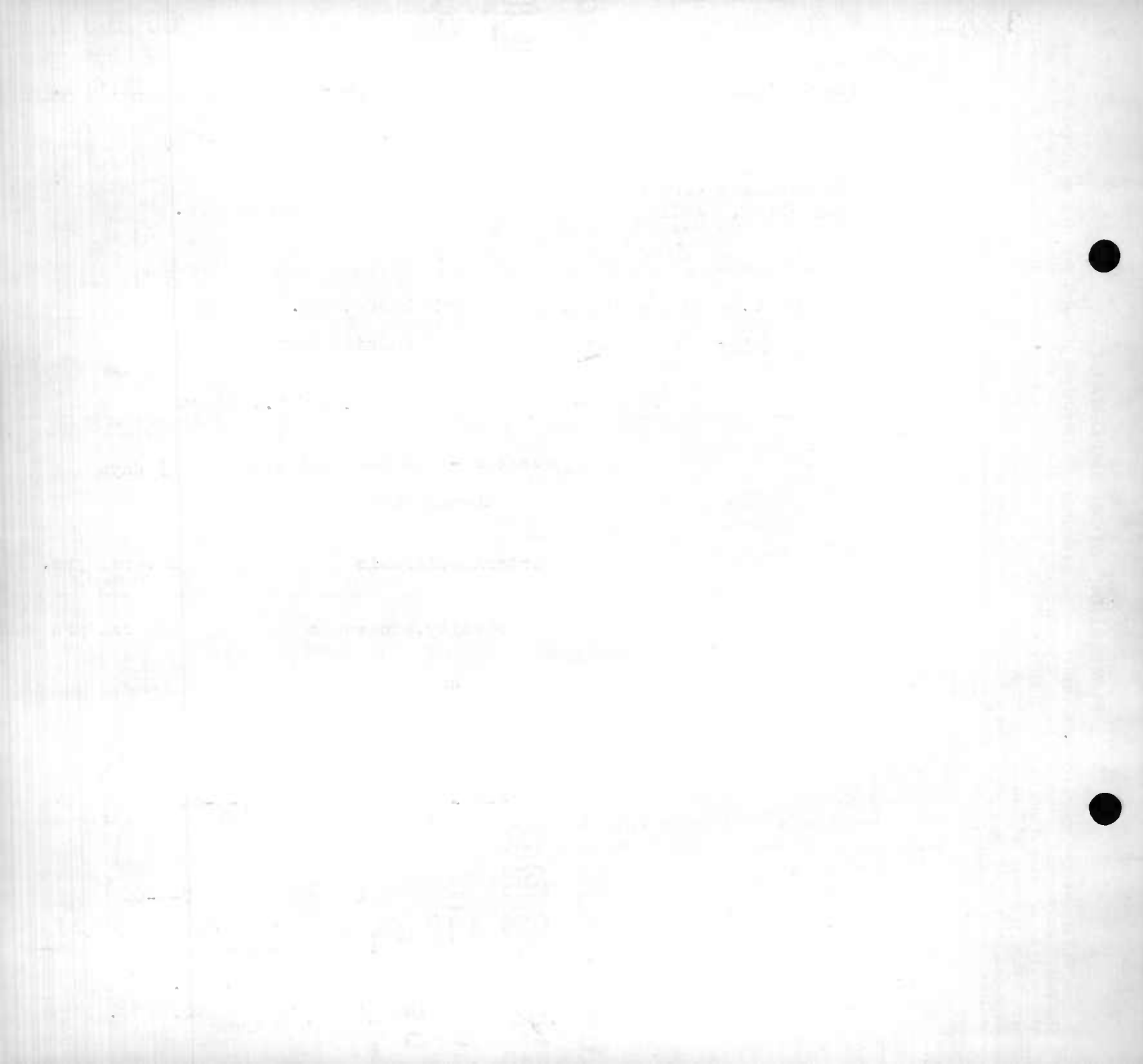
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06905		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06905	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Joseph J. Stuchinski				7/2/66 2:35 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital				A. STATE B. COUNTY Maryland AA			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 52-00			
				D. STREET ADDRESS (If rural, give location) 301 West Arundel Road - #25			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 2/23/09	9. AGE (in years last birthday) 57	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Maker Construction		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Stuchinski				14. MOTHER'S MARDEN NAME Josephine			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 1927-1936		16. SOCIAL SECURITY NO. 209-05-2182		17. INFORMANT ADDRESS Mrs Mary Stuchinski 301 W. Arundel Rd, Balto, Md			
18. 381/1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Hepatic Coma DUE TO (B) Laennec's Cirrhosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 1 19 66 to JULY 2 19 66, that (I) (we) last saw the deceased alive on JULY 2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE COLEEN C. HEINRITZ M.D.				23B. DATE SIGNED 7-2-66			
23C. PHYSICIAN'S NAME (Type) COLEEN C. HEINRITZ M.D.				23D. ADDRESS SOUTH BALTIMORE GENERAL HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 8 1966		24C. NAME OF CEMETERY or CREMATORY Meadowbrook Mem. Pk		24D. LOCATION (City, town, or county) (State) Dorsey, Howard Co., Md	
25A. DATE RECORDED IN HEALTH DEPT		25B. NAME OF REGISTRAR Robert E. Stanley, M.D.		25C. FUNERAL DIRECTOR George J. Ronce		ADDRESS 4001 Ritchie Hwy	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

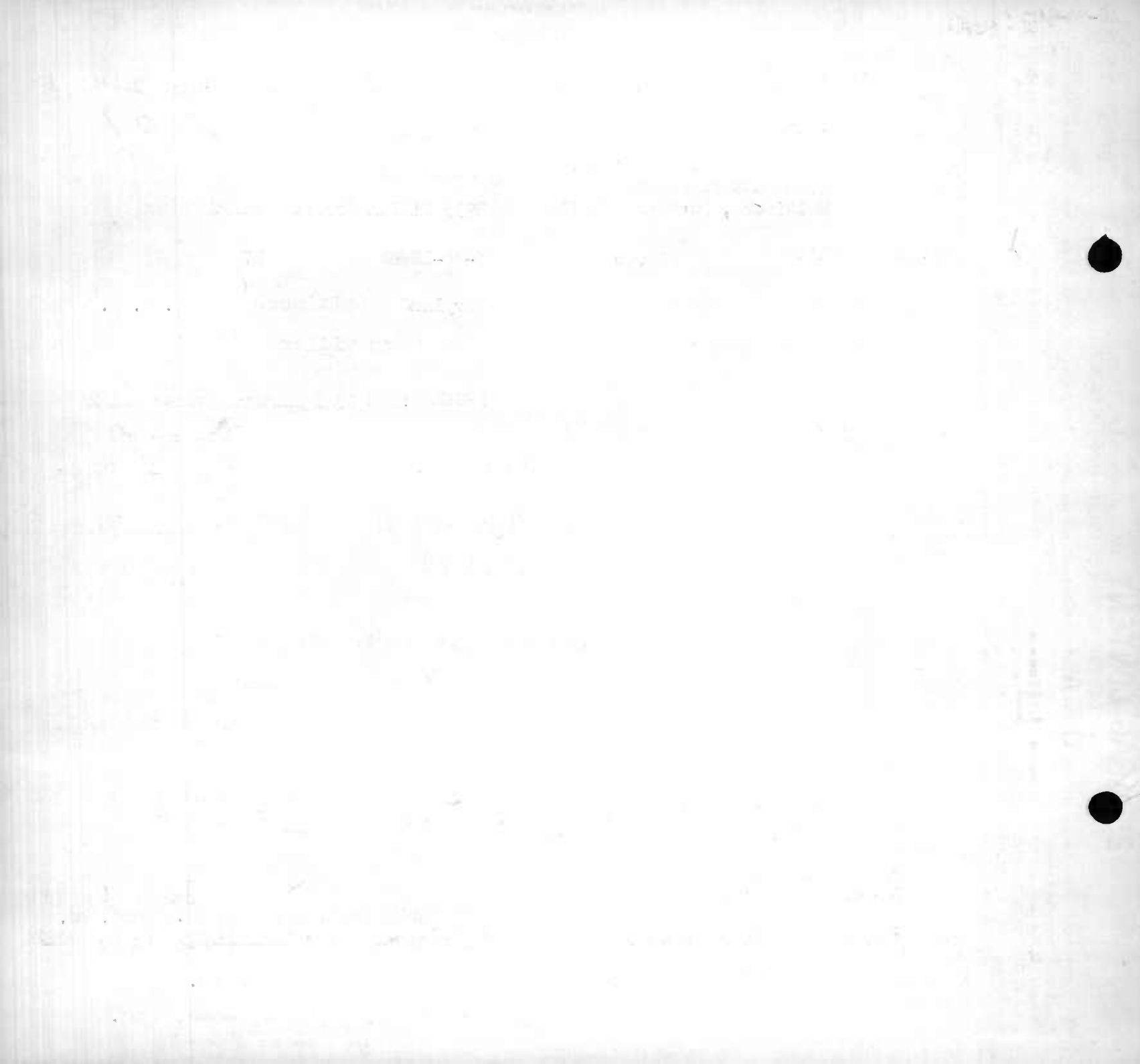
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06906</u>	
BIRTH NO. <u>66 06906</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Frances Pearl Wills</u>		2. DATE AND HOUR OF DEATH <u>7-5-66</u> <u>11:10 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BOLTON HILL NURSING HOME</u> <u>LAFAYETTE & JOHN STREETS</u> <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>27-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3717½ Echodale Ave.</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>divorced</u>	8. DATE OF BIRTH <u>4/24/1881</u>	9. AGE (In years lost birthday) <u>85</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady (Ret.)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Keith Theatre</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>George Hinkler</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Berkley</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-6547A</u>		17. INFORMANT <u>Ruth Hanna, dght., above</u>	
18. <u>3320X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>obesity, exogenous</u>		(A) <u>cerebro-vascular accident</u> DUE TO <u>thrombosis</u> (B) <u>arteriosclerosis</u> DUE TO <u>several yrs.</u> (C) <u>several yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-25-66</u> to <u>7-5-66</u> and that (I) (we) last saw the deceased alive on <u>July 4</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE <u>RK GUNORY</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7-6-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>RK GUNORY</u>		23D. ADDRESS <u>2 W University Pkwy, 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/8/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D <u>JUL 8 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, Jr.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <u>Matilda Ritterpusch</u>		2. DATE AND HOUR OF DEATH <u>July 5, 1966 2:40 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2933 Dillon Street 21224</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5-26-1889</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE (In years last birthday) <u>77</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Waudby</u>		14. MOTHER'S MAIDEN NAME <u>Mary Miller</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>RECORDS: BCH 4940 Eastern Avenue 21224</u>
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Aspiration pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Myocardial infarction</u> <u>ASCVD</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <u>2 days</u> <u>2 days</u> <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Cerebral vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>June 11</u> 19 <u>66</u> to <u>July 5</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 5</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Ross T. Krueger</u>		23B. DATE SIGNED <u>July 5, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ross T. Krueger</u>		23D. ADDRESS <u>4940 Eastern Avenue Baltimore, Md.</u> <u>Baltimore City Hospitals 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/9/66</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>	25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>



1
5-652

66 06908

BALTIMORE CITY HEALTH DEPARTMENT

66 06908

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Katherine M. Scharnagle

2. DATE AND HOUR PRONOUNCED DEAD

7/5/66

11:15 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7749 Wynbrook Rd.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

divorced

8. DATE OF BIRTH

7/8/1897

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Carl Sperling

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

216-10-7414B

17. INFORMANT

ADDRESS

Katherine Scharnagle, dght. above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/5/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/8/66

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 8 1966

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
3331 Brehms Lane

ADDRESS

WALTER E. BROWN

66 06909

BALTIMORE CITY HEALTH DEPARTMENT

66 06909

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William H. Wilder

2. DATE AND HOUR PRONOUNCED DEAD

7/5/66 1:47 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4100 Dudley St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

8/24/1904

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mail Carrier

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Post Office

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Wilder

14. MOTHER'S MAIDEN NAME

Nannie Pearsol

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

212-42-9320

17. INFORMANT

ADDRESS

Albina Wilder, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/5/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/8/66

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 8 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
3331 Brehms Lane

ADDRESS

VALLEY FORCE

ADDITIONAL

23 April

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06910</u>	
BIRTH NO. <u>66 06910</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ALEXANDER TOLSON</u>		2. DATE AND HOUR OF DEATH <u>7-5-66</u> <u>14.45</u> P.M.	
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2002</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u>		D. STREET ADDRESS (If rural, give location) <u>2756 KINSEY AVENUE</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> (specify)	8. DATE OF BIRTH <u>8- -01</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>CHARLES TOLSON</u>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-075541</u>		17. INFORMANT ADDRESS	
18. <u>204.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>PNEUMONIA</u> (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>CHR LYMPHOCYTIC LEUKEMIA</u> (B) DUE TO (C) <u>3 YRS</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>July 5</u> 19 <u>66</u> to <u>July 5</u> 19 <u>66</u> , that (I) <u>(not)</u> lost saw the deceased alive on <u>July 5</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(not)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. Meshkin</u>				23B. DATE SIGNED <u>July 5/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. Meshkin</u>		23D. ADDRESS <u>Johns Hopkins Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-9-66</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION (City, town or county) (State) <u>Bald Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Ferguson</u>	
25C. FUNERAL DIRECTOR <u>C. E. Wright</u>		25D. ADDRESS <u>2700 Edmondson</u>			

CHURCH

CH

CHR LAMBETH
LONDON

2 July 2

2 July 2


2 July 2

2 July 2
2 July 2

2 July 2
2 July 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06911		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06911	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) NICHOLAS MITSOS			2. DATE AND HOUR OF DEATH JULY 6, 1966 8:45 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3814 MAYBERRY AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 11-16-44	9. AGE (In years last birthday) 21	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME ZEFF MITSOS			14. MOTHER'S MAIDEN NAME STELLA ZONARAS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT AND CATON AVENUE ST. AGNES HOSPITAL RECORDS, WILKENS		
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Schizophrenia			CAUSE OF DEATH (A) Acute Renal Failure & Uremia DUE TO (B) Pneumonitis Rt Lung DUE TO (C) Possible Septicemia Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XI (this hospital) attended the deceased from JULY 5 19 66 to JULY 6 19 66 , that XI (we) last saw the deceased alive on JULY 6 19 66 and that in XI (our) opinion death occurred on the date and hour and from the causes stated above XI (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED 7-7-66		
23C. PHYSICIAN'S NAME (Type) RAFAEL MARIN			23D. ADDRESS ST AGNES HOSPITAL, BALTO. 29, MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE JUL 8/9/66	24C. NAME of CEMETERY or CREMATORY Greek Orthodox Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd.	

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

CHICAGO, ILL.

APRIL 1954

TO THE PHYSICS DEPARTMENT

OF THE UNIVERSITY OF CHICAGO

FROM THE PHYSICS DEPARTMENT

OF THE UNIVERSITY OF CHICAGO

CHICAGO, ILL.

APRIL 1954

TO THE PHYSICS DEPARTMENT

OF THE UNIVERSITY OF CHICAGO

CHICAGO, ILL.

APRIL 1954

TO THE PHYSICS DEPARTMENT

OF THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06912		CERTIFICATE OF DEATH		Registered No. 66 06912	
1. NAME OF DECEASED (Type or Print) ELIZABETH ANN BURBETT				2. DATE AND HOUR OF DEATH 7-6-66 @ 8¹⁰ PM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD B. COUNTY 26-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 134 S. East Ave					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3-9-1897	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY -			11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ANDREW MATTHEWS			14. MOTHER'S MAIDEN NAME ELIZABETH OWENS			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 212095636			17. INFORMANT ADDRESS Mrs. May G. Hardy-6727 Queens Ferry Rd. #12						
18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) pul. embolism DUE TO probably secondary to cerebral - stroke (B) 9 day post-op DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Y. K. Brain, H.W.									
19A. DATE OF OPERATION 6-28-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED STRESS URINARY INCONTINENCE		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 27 19 66 to July 6 19 66 , that (I) (the) last saw the deceased alive on July 6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Hong Chul Yoon				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-6-66			
23C. PHYSICIAN'S NAME (Print) HONG CHUL YOON				23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/66		24C. NAME of CEMETERY or CREMATORY Oaklawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd. #14					

1-1-12 1-1-12

MD

PHYSICIAN

GENERAL HOSPITAL

134 2 2nd Ave

3-9-12 12:30

Wounded

H

12:30 12:30

-

Hospital

ELIZABETH OLSON

ANDREW MATTHEWS

4-28-12 12:30 12:30

July 4 12:30 12:30

4-2-12

✓

Stacy Clinic

THE LINDA RICHARD V. ROSE TAT

12:30 12:30

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06913		CERTIFICATE OF DEATH		Registered No. 66 06913	
1. NAME OF DECEASED (Type or Print) ALTON JACOB DURNAM				2. DATE AND HOUR OF DEATH JULY 7-66 8:00 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSP.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4107 KINSWAY Rd. #6					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 9-4-04		9. AGE (In years lost birthday) 61		If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXX Machinest		10B. KIND OF BUSINESS OR INDUSTRY Martin Co.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME FRANKLIN PIERCE DURNAM				14. MOTHER'S MAIDEN NAME Clarrissa Kean					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212077010		17. INFORMANT ADDRESS Mrs. Mildred Durham- Same					
18. 294X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) CEREBRAL VASCULAR ACCIDENT DUE TO (B) GENERALIZED ARTERIOSCLEROSIS DUE TO (C) POLYCYTHEMIA VERA				INTERVAL BETWEEN ONSET AND DEATH 48 hr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5 JULY 19 66 to 7 JULY 19 66 , that (I) (we) last saw the deceased alive on 7 JULY 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Sidney E. Kirby				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7 JULY 66			
23C. PHYSICIAN'S NAME (Type) SIDNEY E. KIRBLEY				23D. ADDRESS THE UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/66		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS 5305 Harford Rd. #14			

THE TOWN OF WEST VIL

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 06914					CERTIFICATE OF DEATH		Registered No. 66 06914		
1. NAME OF DECEASED (Type or Print) MRS. AGNES KIERR (VANMETER)					2. DATE AND HOUR OF DEATH 7/5/66 9:00 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & Hospital					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 15-10				
5. SEX FEMALE 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW					8. DATE OF BIRTH 11/11/1908 9. AGE (In years last birthday) 67				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY AT HOME				
11. BIRTHPLACE (State or foreign country) Missouri					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME FRANK CAPLAN					14. MOTHER'S MAIDEN NAME JETTY Siff				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. RUTH KIERR				
17. INFORMANT RUTH KIERR					ADDRESS 4001 Liberty Hqts. BALTO, Md.				
18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma					INTERVAL BETWEEN ONSET AND DEATH MONTHS				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION NONE					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? —					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —				
21E. INJURY OCCURRED —					21F. HOW DID INJURY OCCUR? —				
22. I certify that (if this hospital) attended the deceased from 6/11/1966 to 7/5/1966 , that (if we) last saw the deceased alive on 7/5/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Francisco A. Baltazar, Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED July 5, 1966				
23C. PHYSICIAN'S NAME (Type) FRANCISCO A. BALTAZAR, JR.					23D. ADDRESS CHURCH HOME & Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 7/6/66				
24C. NAME OF CEMETERY or CREMATORY SHAAREI ZION CONG.					24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND				
25A. DATE REC'D. BY HEALTH DEPT. JUL 8 1966					25B. NAME OF REGISTRAR Robert E. Farber, M.D.				
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN					ADDRESS				

Francisco A. BARTAR. de. Church Home & Hospital
+ Just City

Francisco A. Bartar. de.

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Metastatic Carcinoma. Adenoma

RUTH KIER
BARTAR

Letter 2iff

Mission

NSA

Female White Window

4/1/12 67

ESALIMORE

Church Home & Hospital

Good Library

Good Library

Released as a non-medical examiner's class Dr. Britenick

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06915		CERTIFICATE OF DEATH		Registered No. 66 06915			
1. NAME OF DECEASED (Type or Print) LEISE, ELLIS				2. DATE AND HOUR OF DEATH 7-5-66 6:30 P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) H SINAI HOSPITAL OF BALTIMORE BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY BALT C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-20 D. STREET ADDRESS (If rural, give location) 3808 CEDAR DRIVE							
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 5-1-98	9. AGE (In years last birthday) 68	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCE		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 413-32-6906				17. INFORMANT MRS. LENA LEISE, 3808 CEDAR DRIVE #7				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 180X I RECURRENT CA 2 METASTASIS TO POSTERIOR ABDOMINAL C SEVERE BLEEDING HYPERNEPHROMA (L) KIDNEY				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 7-5-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED METASTATIC TUMOR 2 HEMORRAGE		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from June 6 1966 to July 5 1966, that (I) (we) last saw the deceased alive on July 5 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE CLARO L. PRO RDA				23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type) CLARO L. PRO RDA		23D. ADDRESS SINAI HOSPITAL BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/6/66		24C. NAME OF CEMETERY or CREMATORY BNAT ISRAEL CONG.		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISERSTOWN		ADDRESS					

SECRET

1. The following information was obtained from a source who has provided reliable information in the past.

2. The source has provided information that is of a confidential nature and should be handled accordingly.

3. The information was obtained from a source who has provided reliable information in the past.

4. The source has provided information that is of a confidential nature and should be handled accordingly.

5. The information was obtained from a source who has provided reliable information in the past.

6. The source has provided information that is of a confidential nature and should be handled accordingly.

7. The information was obtained from a source who has provided reliable information in the past.

8. The source has provided information that is of a confidential nature and should be handled accordingly.

9. The information was obtained from a source who has provided reliable information in the past.

10. The source has provided information that is of a confidential nature and should be handled accordingly.

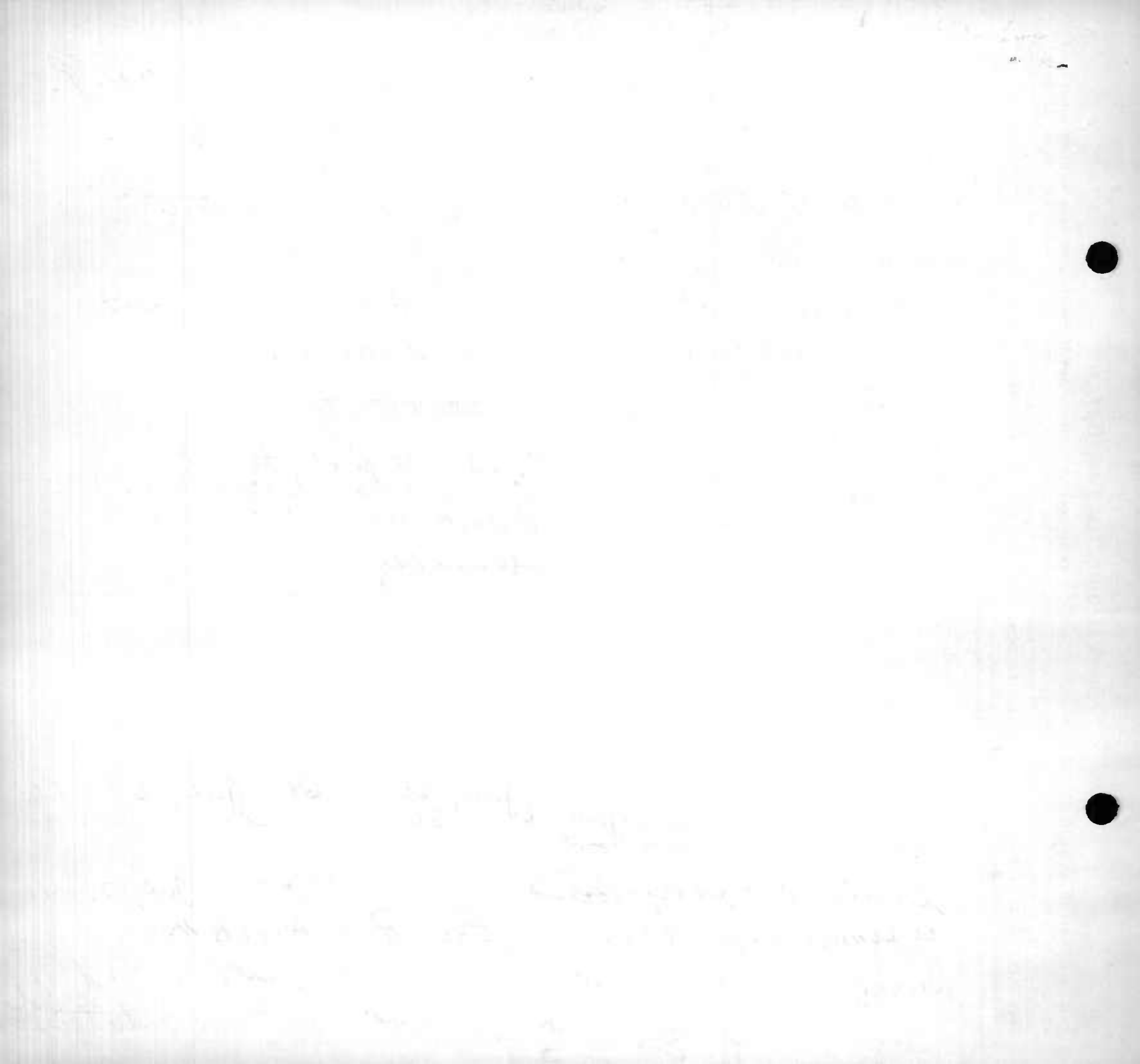
11. The information was obtained from a source who has provided reliable information in the past.

12. The source has provided information that is of a confidential nature and should be handled accordingly.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 06916		BALTIMORE CITY HEALTH DEPARTMENT		Certificate of Death		Registered No.		66 06916	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
				Leah Goodman				July 6, 1966 4:30 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY							
Century Nursing Home				Maryland				4-02			
90 102 N. Poca Street				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore			
				D. STREET ADDRESS (If rural, give location)				102 N. Poca Street			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
Female		White		Widowed		1884		82			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				at home				Poland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
unknown				unknown							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS	
no						NURSING HOME RECORDS					
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES				(A) DUE TO				Cardio-Respiratory Failure			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO				Cerebral Vascular Accident, massive			
				(C) DUE TO				Hypertensive - art. OUTD			
								Senility			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
0											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from July 28 1964 to July 6 1966, that (I) (we) last saw the deceased alive on July 6 1966 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Willard Appleperd M.D.				July 7, 1966							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
Willard Appleperd M.D.				5507 Park Heights Dr.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		July 8/66		Oheb Shalom		Baltimore, Md					
25A. DATE RECEIVED BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
JUL 8 1966		Robert E. Taylor		Sol Leunow		Pete - 6010 Reisterstown Rd					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06917</u>	
BIRTH NO. <u>66 06917</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ABRAHAM R. GRIBOV</u>		2. DATE AND HOUR OF DEATH <u>7/6/66</u> <u>12.30 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>LEVINDALE HEBREW HOME & INFIRMARY</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u> B. COUNTY <u>15-12</u>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		D. STREET ADDRESS (If rural, give location) <u>3439 PARK HEIGHTS AVENUE</u>			
5. SEX <u>M</u>	6. RACE <u>F</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u>	8. DATE OF BIRTH	9. AGE (In years lost birthday) <u>89</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>WHITE RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>AARON GRIBOV</u>		
14. MOTHER'S MAIDEN NAME <u>FANNIE WEINSTEIN</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>46-07-9961A</u>			17. INFORMANT ADDRESS <u>MR. JOEL A. LEVIN, 3636 FOREST HILL ROAD</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>NOT KNOWN</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>		<u>NOT KNOWN</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (M) (this hospital) attended the deceased from <u>7/6/11/25</u> 19 <u>59</u> to <u>7/6/1</u> 19 <u>66</u> , that (H) (we) last saw the deceased alive on <u>7/6/1</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George Berenick</u>				23B. DATE SIGNED <u>7/6/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. G. BERCU</u>				23D. ADDRESS <u>LEVINDALE HEBREW HOME & INFIRMARY</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL JUL 87/1966</u>		24B. DATE <u>87/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE HEBREW CONG.</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>8/1/66</u>			
25B. NAME OF REGISTRAR <u>Robert E. Barber</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN</u>			

Y

12/13/12

11

Yes

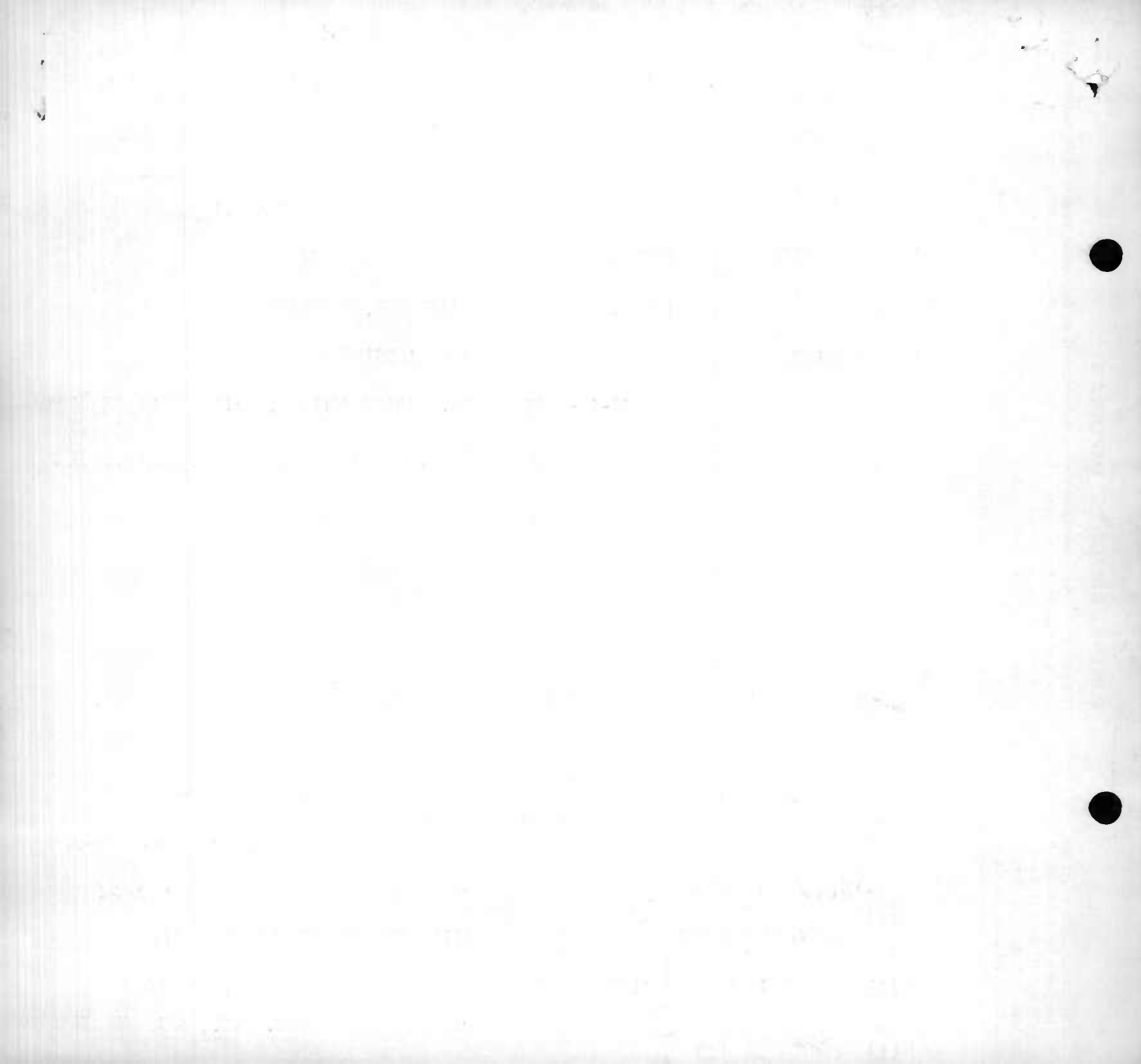
12/11/12

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

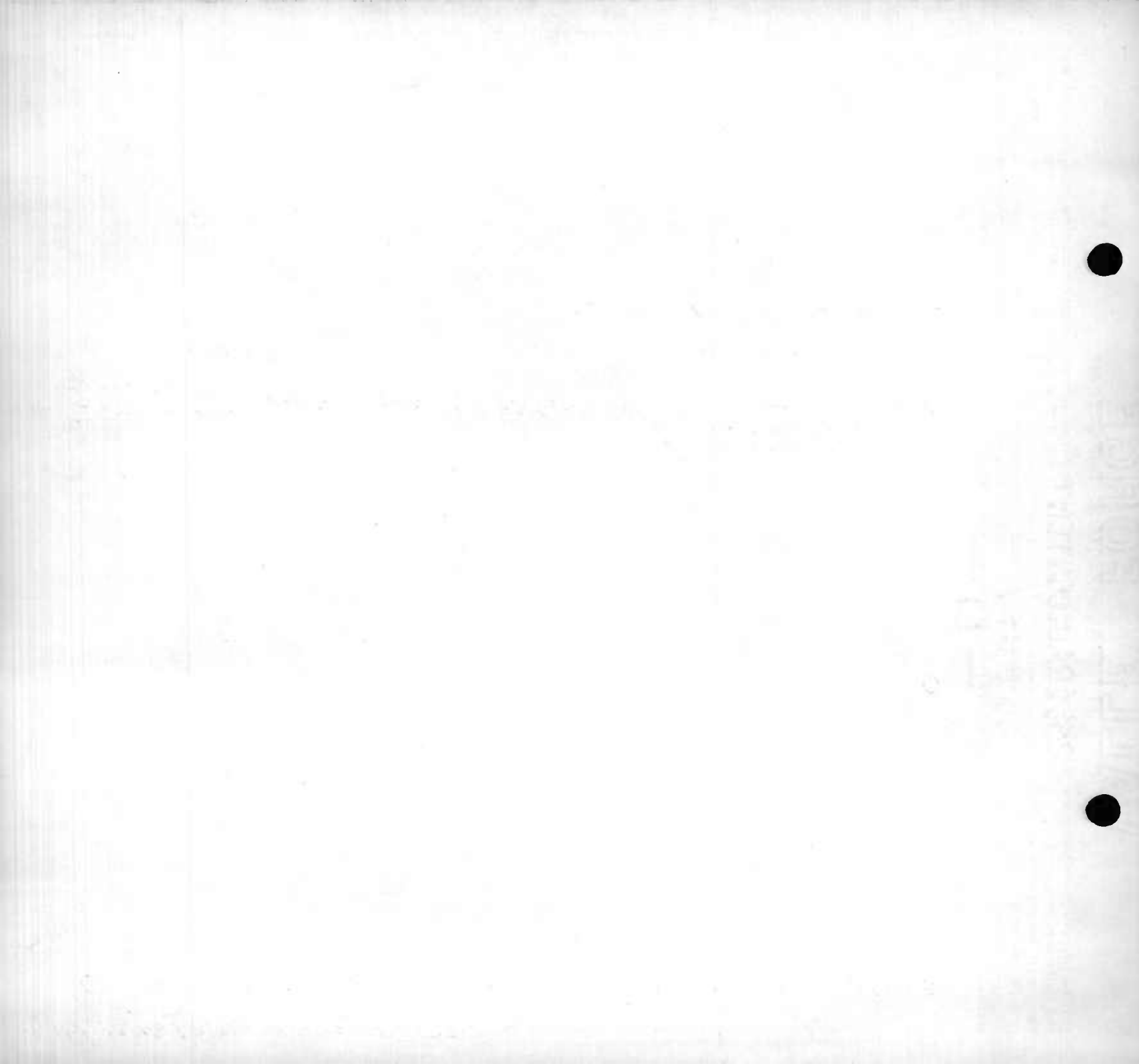
BIRTH NO. 66 06918				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06918	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MORRIS KESSLER				JULY 6, 1966		10:30 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL (If not in hospital or institution, give street address or location)				A. STATE MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 2419 FOREST GREEN ROAD #9			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DESIGNER		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JULIUS KESSLER			14. MOTHER'S MAIDEN NAME IDA SLESSINGER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-10-0827	17. INFORMANT ADDRESS MRS. MARLYN HOLZMAN, 2419 FOREST GREEN ROAD				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11 ACUTE MYOCARDIAL INFARCTION DUE TO CORONARY ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH sudden death 2 yrs.							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1962 to present that (I) (we) last saw the deceased alive on 6-2-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Brought to Sinai Hosp.							
23A. SIGNATURE Sheldon C. Kravitz				23B. DATE SIGNED 7-7-66			
23C. PHYSICIAN'S NAME (Type) SHELDON KRAVITZ				23D. ADDRESS M.D. 6715 PARK HEIGHTS AVENUE #15			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/8/66		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <u>66 06919</u>					
BIRTH NO. <u>66 06919</u>					M.E. CASE NO. _____					
1. NAME OF DECEASED (Type or print) <u>Rodecker, Mr. George</u>					2. DATE AND HOUR OF DEATH <u>7/6/66</u> <u>12 mn</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hosp.</u>					A. STATE <u>md.</u> B. COUNTY <u>Harford</u>					
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Joppa town</u> <u>62-00</u>					
					D. STREET ADDRESS (If rural, give location) <u>915 Averil</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5/28/85</u>	9. AGE (In years last birthday) <u>81</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jake Rodecker</u>					14. MOTHER'S MAIDEN NAME <u>Minnie KEEFER</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>109-28-3605A</u>					17. INFORMANT <u>Mrs. Rose Rodecker, 915 Averil Rd. Joppa town, 21085</u>
18. <u>420.04-177X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Congestive heart failure</u>					CAUSE OF DEATH (A) DUE TO <u>myocardial insufficiency</u>					INTERVAL BETWEEN ONSET AND DEATH <u>months</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Heart disease</u>					(B) DUE TO <u>years</u>					(C) DUE TO <u>years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Ca of the prostate gland.</u>										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR?		If in Baltimore City, give exact location			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Juan F. Sordo</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <u>JUAN F. SORDO</u>					23D. ADDRESS <u>BON SECOURS HOSPITAL</u>					
24A. BURIAL REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-9-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>OAK LAWN CEMETERY</u>			24D. LOCATION (City, town, or county) (State) <u>BALTIMORE COUNTY, MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1966</u>					25B. NAME OF REGISTRAR <u>Robert E. Sanborn</u>		25C. FUNERAL DIRECTOR ADDRESS <u>ULLRICH FUNERAL HOME, DUNDALK, MD.</u>			



B-535

66 06920

BALTIMORE CITY HEALTH DEPARTMENT

66 06920

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		RONALD BENTON		2. DATE AND HOUR PRONOUNCED DEAD July 4, 1966 7:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2101 Maryland Avenue		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2101 Maryland Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH May 10, 1905	9. AGE (In years last birthday) 61	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Air Kool Fan Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Alexander Benton		14. MOTHER'S MAIDEN NAME Olive Tawes		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-10-4563		17. INFORMANT ADDRESS Miss Pat Benton, 1436 Covington St. Baltimore 30, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchial Asthma					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7/7/66		23C. NAME of CEMETERY or CREMATORY St. Paul's Cemetery	
24A. DATE REC'D BY HEALTH DEPT. July 4, 1966		24B. NAME OF REGISTRAR Robert E. Fisher, M.D.		24C. FUNERAL DIRECTOR ADDRESS L. G. Webster Princess Anne, Md.	

9/16/66 - Minister's Marriage record from Clerk of Circuit Court, Howard County, Md.
Date of marriage, May 10, 1947.

Copy of search of records by Clerk of Circuit Court, Baltimore City certifying
that there is no court record of divorce from Jan. 1, 1947 to Dec. 15, 1966.
Clerk: Henry J. Ripperger, 9/15/66.

Court record from Circuit Court No. 2, G. Gordon Kirby, clerk stating that there
is no record of divorce from Sept. 1948 to Sept. 15, 1966.

SPB JEC.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

JOHN

HENSON

2. DATE AND HOUR PRONOUNCED DEAD

July 3, 1966

10:20 P.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

822 N. Carrollton Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

822 N. Carrollton Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

W

8. DATE OF BIRTH

9. AGE (in years
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Laborer

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

Mid

13. FATHER'S NAME

Macellus

Henson

14. MOTHER'S MAIDEN NAME

Jennie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

216-12-3796

17. INFORMANT

Carrie Pindell

ADDRESS

822

7 Carrollton Ave

18.

42211

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A)

Arteriosclerotic cardiovascular

~~OTHER~~

disease

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 4, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

7-9-66 Mt Auburn

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Barto Md

24A. DATE REC'D BY HEALTH DEPT.

JUL 8 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Mrs Francis A. Hamby 11 Biddle St

ADDRESS 578

MEMORANDUM FOR THE RECORD

DATE: 10/10/1964

TO: Mr. Tolson
FROM: Mr. DeLoach
SUBJECT: [Illegible]

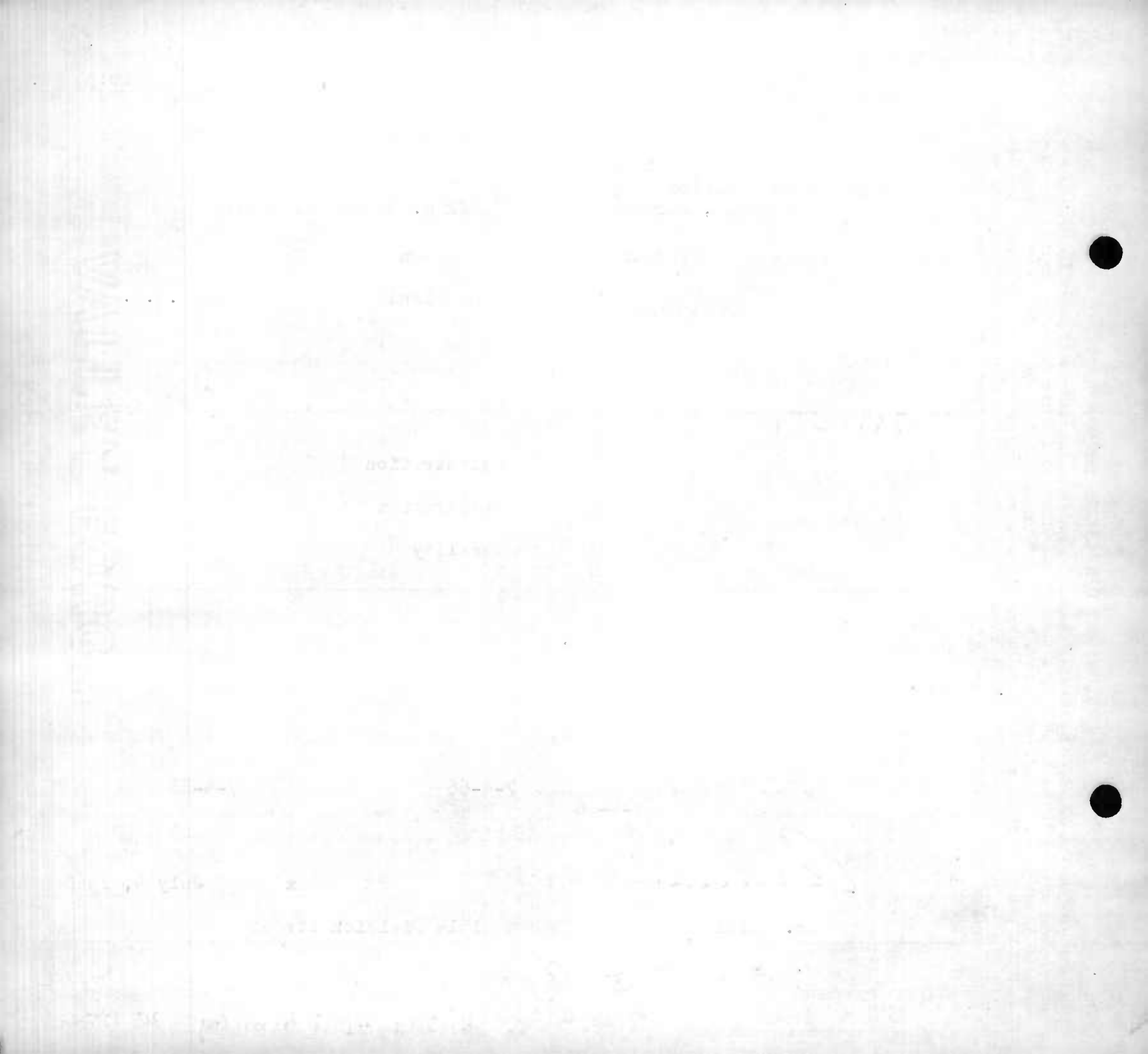
[Illegible body text]

2-1-10 [Illegible]
[Illegible]

FUNERAL DIRECTOR: IMPORTANT

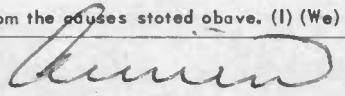
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06922</u>	
BIRTH NO. <u>66 06922</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Julia Davis</u>		2. DATE AND HOUR OF DEATH <u>July 4, 1966</u> <u>10:35 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39 Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>		A. STATE <u>Maryland</u> B. COUNTY <u>16 VI</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>822 N. Carrollton Avenue</u> <u>CARROLLTON</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Unknown</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>J. Roman</u>		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Carrie Pindell</u>		ADDRESS <u>822</u>
18. <u>28651</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Malnutrition</u> DUE TO (B) <u>Dehydration</u> DUE TO (C) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-4-66</u> 19 to <u>7-4-66</u> 19, that (I) (we) last saw the deceased alive on <u>7-4-66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>July 4, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Amini</u>		23D. ADDRESS M.D. <u>1514 Division Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7-9-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balto</u> <u>md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fackler</u>		25C. FUNERAL DIRECTOR <u>Mr. Francis A. Hennley</u>	
				ADDRESS <u>558 W Biddle St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06923		CERTIFICATE OF DEATH		Registered No. 66 06923	
1. NAME OF DECEASED (Type or Print) Ozella Woodfolk				2. DATE AND HOUR OF DEATH July 4, 1966		9:00 p. m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 507 Lafayette Avenue					
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-8-04	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) C.C. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Ceaser Dare				14. MOTHER'S MAIDEN NAME Bessie Kent					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 28-30-5357		17. INFORMANT George Woodfolk		507 W. ADDRESS *- Lafayette St		
18. 35-2X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Myelitis DUE TO (B) Paraplegia DUE TO (C) Cystitis Pericent		INTERVAL BETWEEN ONSET AND DEATH From 6/1/66 until 7/4/66			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 1, 1966 to July 4, 1966 , that (I) (we) lost saw the deceased alive on July 4, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE  M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED July 5, 1966					
23C. PHYSICIAN'S NAME (Type) ATA. AMINI		23D. ADDRESS 1514 Division Street							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-66		24C. NAME of CEMETERY or CREMATORY Natioanal Cem		24D. LOCATION (City, town, or county) (State) Baltimore, Me.			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR (Mrs) Frances A. Hemstey (Mrs) Frances A. Hemstey					

Page 1 of 1
Date: 10/10/10

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06924		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06924	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mary Long (MARY M. LONG)		7-4-66		11 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND		Maryland		26-09	
31		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		639 S. Grundy St. #21224	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days Hours Min.
Female	White	Widowed	6-20-12	54	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House Work		At Home		West Virginia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		Frank Smolarik		Hazel Eva A. Slezak	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-24-0737		#21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 I		Cardiac arrest		2 hours	
ANTECEDENT CAUSES		(A) DUE TO myocardial infarction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4 July 1966 to 4 July 1966, that (I) (we) last saw the deceased alive on 4 July 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Daniel D. Foote				4 July 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Daniel D. Foote		M.D. BCH-4940 Eastern Avenue, Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	7-7-66	Sacred Heart Cemetery		7401 German Hill Rd Ba. Co., MD	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
JUL 8 1966	Robert E. Farley, MD	Charles J. Seiler		901 S. CONKLING ST. BALTO., MD	

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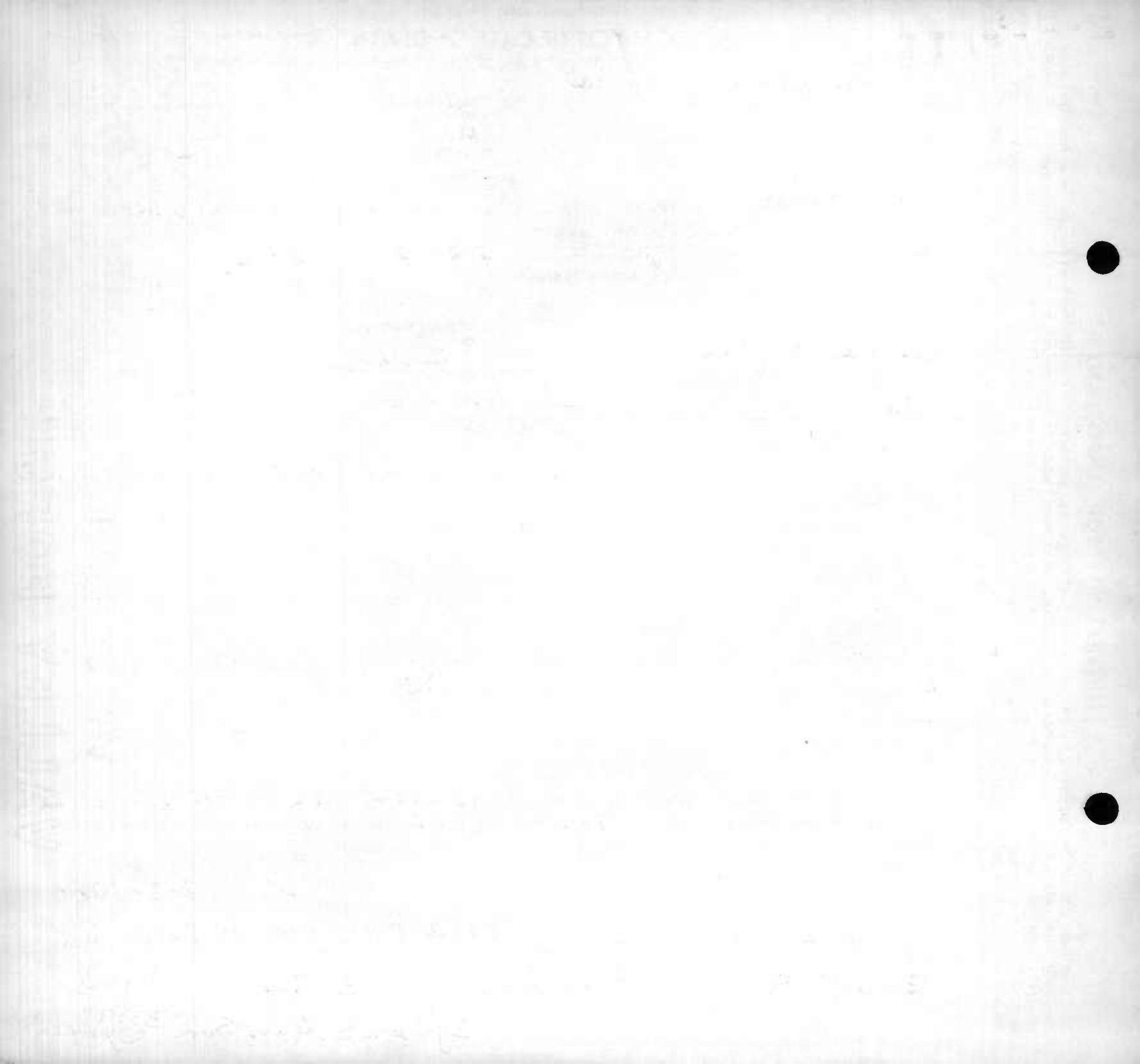
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

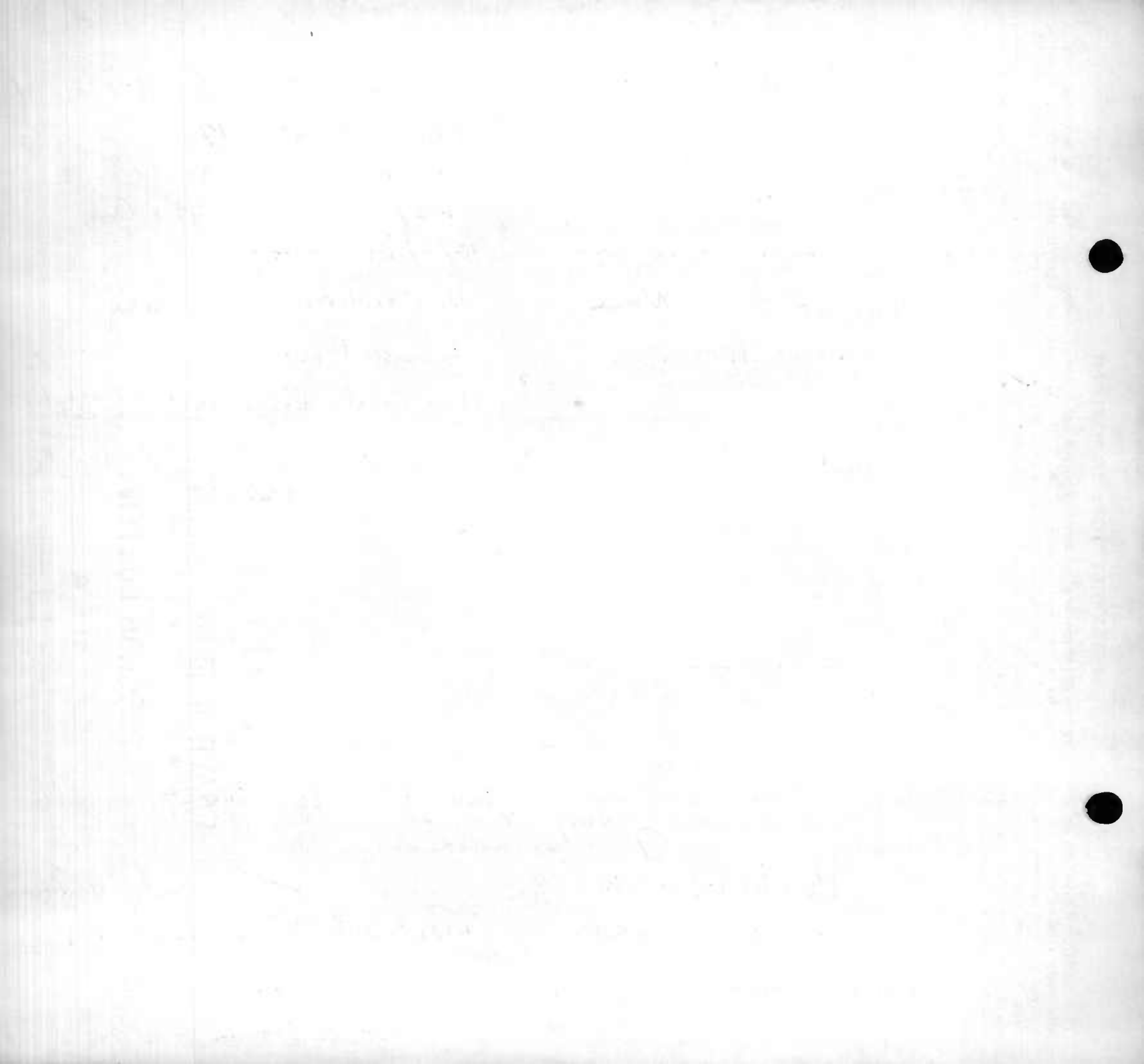
BALTIMORE CITY HEALTH DEPARTMENT						Certificate of Death		Registered No. 66 06925	
BIRTH NO. 66 06925		M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) ZIGMAN, Sophia		2. DATE AND HOUR OF DEATH 7-6-66 6:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Md. B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) LEVINDALE HEBREW HOME & INFIRMARY	
15. SEX F		16. RACE W		17. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W.		18. DATE OF BIRTH 5-8-85		19. AGE (In years lost birthday) 82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Rachman Sugarman						14. MOTHER'S MAIDEN NAME ? Esther			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Esther Gold // 3333 Belle Ave. Baltimore 15, Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
18. H20.11						A. Myocardial Infarction		Few minutes	
18. ANTECEDENT CAUSES						B. ASCVD		Years	
18. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						C.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-19-1966 to 7-6-1966.		that (I) (we) last saw the deceased alive on 7-6-1966 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.							
23A. SIGNATURE Jose Ardaiz		M.D. Attending Phys. Med. Director Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-6-1966					
23C. PHYSICIAN'S NAME (Type) Jose ARDAIZ		M.D. 5912 CROSS COUNTRY BLVD. Baltimore Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/66		24C. NAME OF CEMETERY or CREMATORY Rosedale		24D. LOCATION (City, town, or county) Balto		24E. STATE Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Sylvan S. Lewis		25D. ADDRESS 3319 Olympia			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06926</u>	
BIRTH NO. <u>66 06926</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Mrs. Millie Clark</u>			2. DATE AND HOUR OF DEATH <u>July 7 1966</u> <u>1:30</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Montebello State Hosp.</u>			A. STATE <u>MD</u> B. COUNTY <u>212 17</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
			D. STREET ADDRESS (If rural, give location) <u>1929 W. Lafayette Ave</u>		
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>10/8/88</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Joe srus Person</u>			14. MOTHER'S MAIDEN NAME <u>Louise Person</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>0</u>		16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT <u>Miss Othelia Nicholson</u>		ADDRESS <u>1929 W. Lafayette Ave, Baltimore</u>
18. <u>171X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Cervix with bony metastasis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> 19 <u>66</u> to <u>July 7</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Hea Pean LEW</u> M.D.			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>July 7 66</u>
23C. PHYSICIAN'S NAME (Type) <u>Hea Pean LEW</u> M.D.			23D. ADDRESS <u>Montebello Hosp. Baltimore</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-10-66</u>	24C. NAME OF CEMETERY or CREMATORY <u>Verdellie Cent</u>		24D. LOCATION (City, town, or county) (State) <u>Reesport PA</u>
25A. DATE REC'D IN HEALTH DEPT <u>JUL 9 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Francis Ruth Shaw</u> ADDRESS <u>Pa</u>	



1
L-530

66 06927

BALTIMORE CITY HEALTH DEPARTMENT

66 06927

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Henry Ernest Lind

2. DATE AND HOUR PRONOUNCED DEAD

7/4/66 10:40 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

306 S. Dallas Court

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Sept. 28, 1901

9. AGE (in years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Roland Electric

11. BIRTHPLACE (State or foreign country)

Finland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Clara A. Spriggs 202 S. Patterson Park

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Pulmonary emphysema and purulent bronchitis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

R. BREITENBECKER

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/6/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-8-1966

23C. NAME of CEMETERY or CREMATORY

St. Matthews

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 8 1966

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

Lilly & Zeiler Inc. 1901-07 Eastern Ave.

ADDRESS

VIA

TO: Mr. J. Edgar Hoover

Sub. No. 1001

Re: [illegible]

Enclosure

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation

RECORDED

Index to the file of the Bureau of Investigation

File No. 1001

Date: [illegible]

By: [illegible]

For: [illegible]

Subject: [illegible]

Reference: [illegible]

Remarks: [illegible]

Signature: [illegible]

Title: [illegible]

46-77-41
NW 13230

66 06928

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

66 06928

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

KATHERINE MARIE O'NEILL BUCKHEIT

2. DATE AND HOUR OF DEATH

7/6/66

3:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

4613 Eastern Avenue - 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

4/2/00

9. AGE (In years
lost birthday)
66If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

HENRY - Deceased Lottes

14. MOTHER'S MAIDEN NAME

LILLIAN - Deceased Gale

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS 21224

RECORDS: BCH 4940 Eastern Avenue, Balto. Md.

18.

420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury at complication which caused death.)

(A) DUE TO

MYOCARDIAL INFARCT MINUTES

ANTECEDENT CAUSES

(B) DUE TO

ASCVD

10 YEARS

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/6 1966 to 7/6 1966,
that (I) (we) last saw the deceased alive on 7/6 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

S. D. Kreider

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/6/66

23C. PHYSICIAN'S
NAME (Type)

S. D. Kreider

M.D.

23D. ADDRESS Baltimore City Hospitals
4940 Eastern Avenue, Balto. Md. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

JUL 8-9-1966

24C. NAME of CEMETERY or CREMATORY

Meadowridge Memorial Park

24D. LOCATION

(City, town, or county)

Howard County, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeiler Inc. 1901-07 Eastern Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06929	
BIRTH NO. 66 06929		CERTIFICATE OF DEATH	
M.E. CASE NO. SCHRODT		2. DATE AND HOUR OF DEATH 7/6/66 1:10 P.M.	
1. NAME OF DECEASED (Type or Print) Schrodt, Mary Grace		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21207	
CERTIFICATE AMENDED <i>7/20/66</i>		D. STREET ADDRESS (If rural, give location) 3608 Plateau Avenue	
		12. CITIZEN OF WHAT COUNTRY? USA	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 4-2-89
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Designer		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 84 77
13. FATHER'S NAME William S. Smith		14. MOTHER'S MAIDEN NAME Minnie Philomena Bauer Mimmie Bowers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-01-3829A	
17. INFORMANT Grace E.		ADDRESS John Z. Schneider 3900 N. Charles St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Emboli		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (A.P.P.R.O.X.)	21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/31 19 66 to 7/6 19 66 , that (I) (we) last saw the deceased alive on 7/6/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>W Stan Wilson</i>		23B. DATE SIGNED 7/6/66	
23C. PHYSICIAN'S NAME (Type) W Stan Wilson		23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-9-66	24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE RECEIVED BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Jenkins	
		25C. FUNERAL DIRECTOR Elmerth Amos	
		ADDRESS 4600 Liberty Hgts. Ave. Baltimore, 7 Maryland	

Bapt.record for Mary Grace Smith born 4/2/89 and bapt.4/14/89 at St.Gregory the ^Great
Church in Baltimore,Md.

Letter fro m Sophie N.Thau-Atty.at Law re items on maiden name of mother & Informant (7/20/66)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06930				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06930	
M.E. CASE NO. 54-78-55/E1-A1				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MOORE GEORGE RUSKIN				2. DATE AND HOUR OF DEATH July 6 1966 12:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital				A. STATE B. COUNTY			
5. SEX Male				6. RACE white			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				8. DATE OF BIRTH 02-21-00			
9. AGE (in years lost birthday) 66				10. CITIZEN OF WHAT COUNTRY? American			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				11. BIRTHPLACE (State or foreign country) Baltimore, M.D.			
12. CITIZEN OF WHAT COUNTRY? American				13. FATHER'S NAME GEORGE B MOORE			
14. MOTHER'S MAIDEN NAME NELLIE CROOK				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I			
16. SOCIAL SECURITY NO. YES				17. INFORMANT ADDRESS Louise R. Moore 5315 Norwood Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Acute fibrinous pleural-pericarditis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				TM			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10:15 AM July 6 1966 to 12:30 AM July 6 1966, that (I) (we) last saw the deceased alive on 12:30 AM July 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Sun Young Choi M.D.			
23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type) Sun Young Choi M.D.			
23D. ADDRESS Union Memorial Hospital				24A. BURIAL CREMATION: 24B. DATE 6-9-66			
24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966				25B. NAME OF REGISTRAR Robert E. Farber, M.D.			
25C. FUNERAL DIRECTOR				25D. ADDRESS 4600 Liberty Hights. Ave. Baltimore, 7 Maryland			

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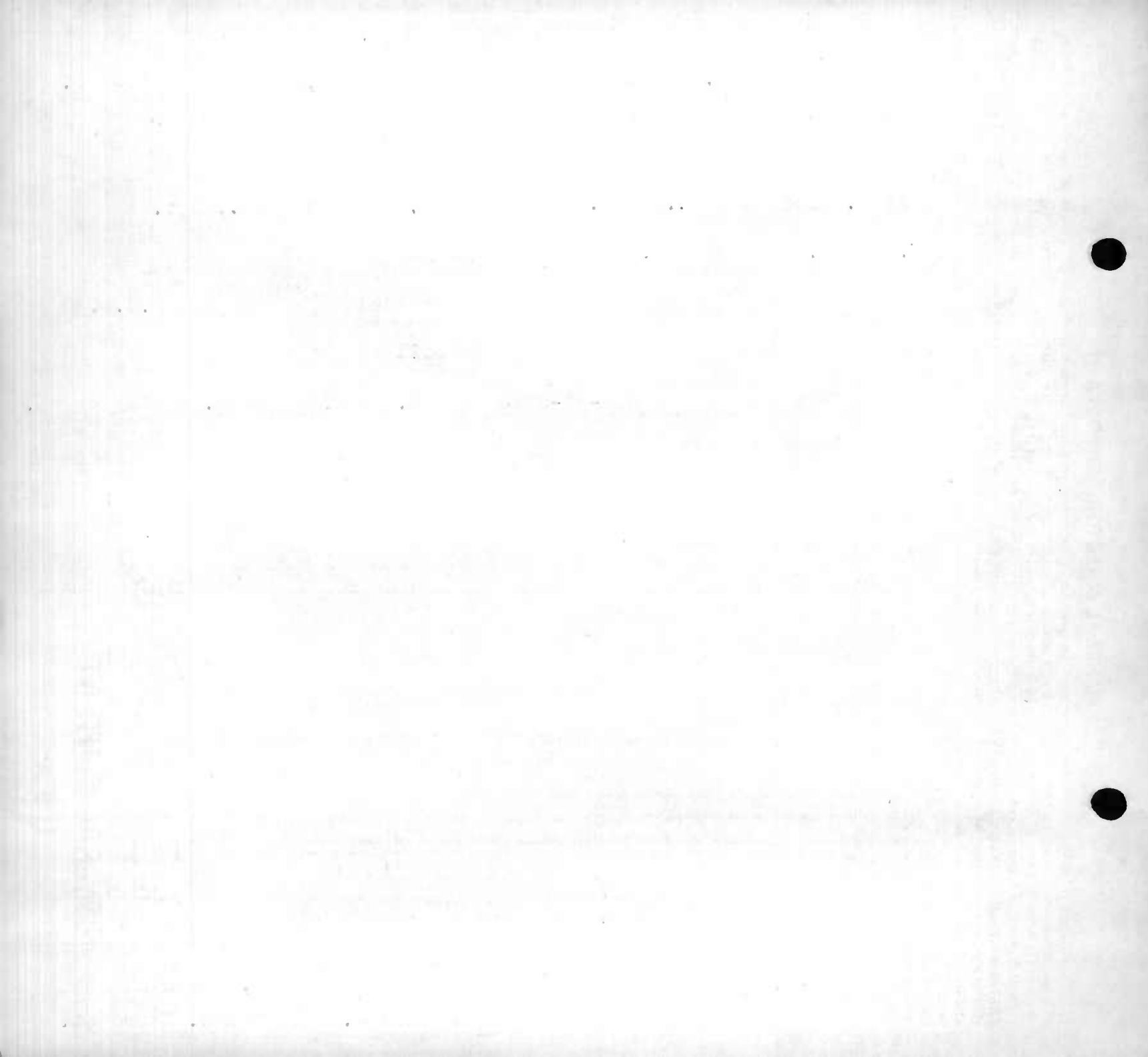
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		Baltimore City Health Department		Registered No. 66 06931	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Nancy W. Francis (Francis)		July 4, 1966		8:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
816 W. Barre Street		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore 21-01			
		D. STREET ADDRESS (If rural, give location)			
		816 W. Barre Street			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days Hours Min.
F.	C.	W.	2/11/91	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John Wesley Williams		Isabelle			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				George Williams 758 W. Hamburg St.	
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Coronary Heart			Sudden
		(B) DUE TO Arterio Sclerotic Heart			2 yrs
		(C) DUE TO Parkinson's Disease			3.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Not White Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1965 to July 4, 1966, that (I) (we) lost saw the deceased alive on July 3, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jerry C. Luck M.D.				23B. DATE SIGNED July 5, 1966	
23C. PHYSICIAN'S NAME (Type) Jerry C. Luck M.D.				23D. ADDRESS 427 Swale Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/9/66		Mt. Auburn	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 8 1966		Robert E. Taylor, M.D.		Charles A. Rice 661 W. Barre St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 06932		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
Howard A. Cornish				July 2, 1966		1:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE					
				Maryland					
904 W. Lexington St., Apt. 11				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				Baltimore					
				D. STREET ADDRESS (If rural, give location)					
				904 W. Lexington St., Apt. 11					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
M.	C.	M.		3/21/88	78				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
						Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Samuel Cornish				Bell					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes WW1				218-07-5745		Emma L. Cornish 904 W. Lexington St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO				acute coronary occlusion a few days	
				(B) DUE TO				Congestive heart failure 2 weeks	
				(C) DUE TO				ASCVD years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Anemia				years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 7-2-66 to 7-2-66, that (I) (we) lost saw the deceased alive on 7-2-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
H. NAKAZAWA				521 W Lexington St					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		7/7/66		Baltimore National		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUL 8 1966				Robert E. Tanaka, M.D.		Charles A. Rice 661 W. Barre St.			



Robertson, Willie

DR. FISHER

ON APPROVAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06933		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06933	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Willie H. Robertson</i>		2. DATE AND HOUR OF DEATH <i>7/4/66</i> <i>12 05</i> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		5. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>1507 North Caroline St.</i>	
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>Separated</i>	8. DATE OF BIRTH <i>11/24/18</i>	9. AGE (In years lost birthday) <i>47</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Material Handler</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Steel Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Raleigh, N.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Unknown Willie Robertson</i>		14. MOTHER'S MAIDEN NAME <i>Unknown Mary Jeffers</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>239-14-5049</i>		17. INFORMANT <i>Willie L. Robertson 2525 Elsinore Ave.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>4-20-11</i> <i>Acute heart failure?</i> <i>arrhythmia, presumption</i> <i>cardiac catastrophe</i> <i>pt. had ASCD and an old MI severe coronary artery dis. 1963</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>7-4-66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7-4-</i> <i>19 66</i> to <i>7-4-</i> <i>19 66</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>7-4-</i> <i>19 66</i> and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above. (I) (<i>we</i>) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard J. Owlen</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7-5-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Richard J. Owlen</i>		23D. ADDRESS <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-9-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Memorial PK.</i>	
24D. LOCATION <i>Arbutus, Md.</i>		24E. NAME of CEMETERY or CREMATORY		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>Randolph Collick</i>	
25D. ADDRESS <i>2431 E. Oliver St.</i>					

First part follows

Arithmetic, geometry

and other subjects

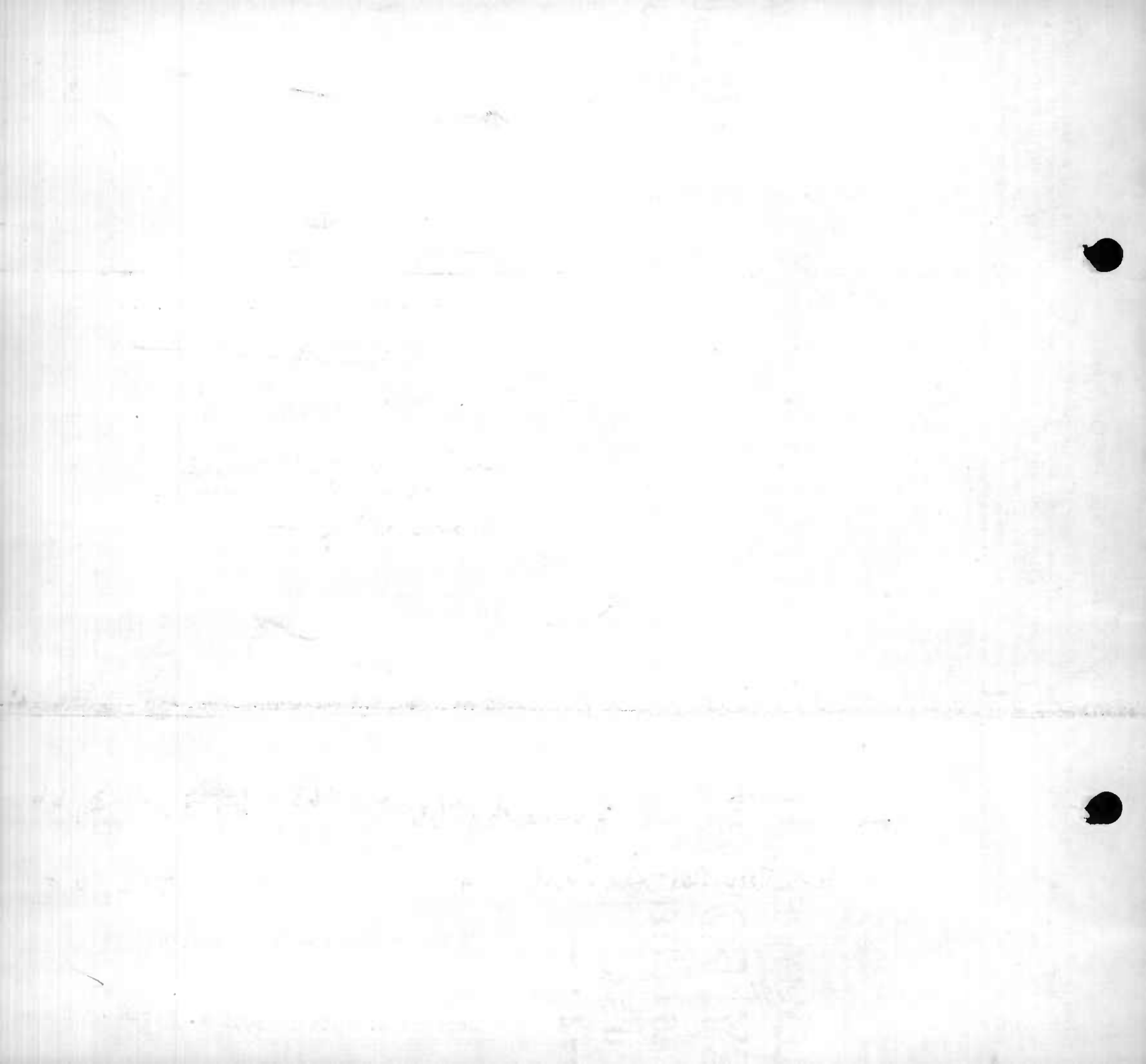
pt. no. 2500 and no. 2501
2500 contains only 1/2 of

W. J. Galt

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

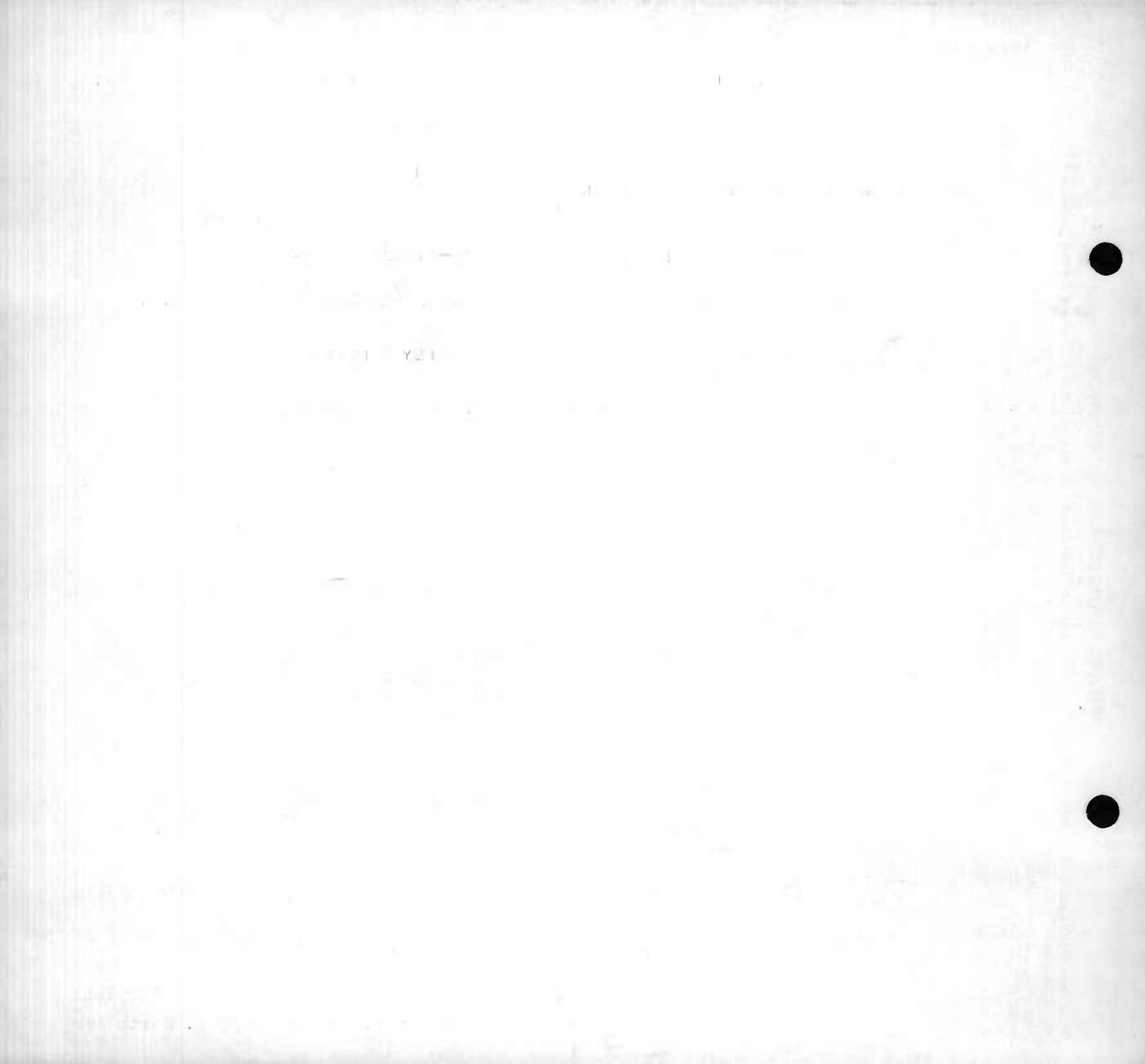
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 06934	
BIRTH NO. 66 06934		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mamie Louise Mills		2. DATE AND HOUR OF DEATH June 29, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 606 N. Carrollton Ave				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 606 N. Carrollton Ave			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH July 11, 1900	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse			10B. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Monetta, South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Albert Wigfall				14. MOTHER'S MAIDEN NAME Lucretia Benjamin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-40-7990		17. INFORMANT Mrs. Bessie Malone	
				ADDRESS 4879 23 rd Street Detroit, Mich.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO arteriosclerotic Heart disease (B) DUE TO Obesity (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 4 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from July 19 63 to June 29 66 that (I) (we) last saw the deceased alive on June 29 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Herman Seidel						23B. DATE SIGNED 7/2/66	
23C. PHYSICIAN'S NAME (Type) Herman Seidel						23D. ADDRESS M.D. 2404 Rutaw Place - Baltimore, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/66		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Arbutus Balto Co. Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Nutter		25C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06935		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06935	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JULIA BREESE		7-4-66		5:45 PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL		MARYLAND		18-02	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		1023 EDMONDSON AVENUE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years)	10. If Under 1 Yr. Months Days
FEMALE	NEGRO	SINGLE	May 6, 1904	62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Domestic		Private Family	Easton, Maryland	U.S.A	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
CHARLES Breese			EMILY MILLER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		220-18-8272	Mr. Wayman Breese 1011 Edmondson Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		years	
ANTECEDENT CAUSES		(B) DUE TO		years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				no	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from June 27 19 66 to July 4 19 66 that (1) (we) last saw the deceased alive on 5:45 PM July 4 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Tah-Hsiung Hsu				7/4/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Tah-Hsiung Hsu				The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/8/66		Richards Cemetery	
				Easton Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 8 1966		Robert E. Farley		Herbert E. Nutter 3035 W. North Ave	



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66 06936

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 06936

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

OLIVIA

BANKS

2. DATE AND HOUR PRONOUNCED DEAD

July 4, 1966

12:37 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

466 Walton Court

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

466 Walton Court

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Sept. 28, 1898

9. AGE (In years
lost birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Elevator Operator

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Alexander Banks

14. MOTHER'S MAIDEN NAME

Isabella Garland

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-05-0223

17. INFORMANT

Mrs. Isabella Fain

ADDRESS

575 Presstman St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular

(A) DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 4, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

7/Burial

23B. DATE

7/7/66

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pl.

23D. LOCATION

(City, town, or county)

(State)

Arbutus Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 8

1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Herbert E. Nutter 3035 W. North Ave.

ADDRESS

VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BIRTH NO. 66 06937		Registered No. 66 06937	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print)		ELMER BERNARD BERTRAND		2. DATE AND HOUR OF DEATH		7-6-66	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
35 CHURCH HOME & HOSPITAL				MARYLAND		6-02	
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED	
M		W		WIDOWED, DIVORCED (specify)		MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MOLD POLISHER		GLASS Co.		10-5-1902		63	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
MARYLAND				U.S.A.		JOHN BERTRAND	
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
MARY MARREE				No		212-03-8457	
17. INFORMANT				18. CAUSE OF DEATH		ADDRESS	
Mrs. Lola M. Bertrand - 420 N. Glover St.				18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				Myocardial infarction approx 1 yr.			
				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
				ANTECEDENT CAUSES			
				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
				II			
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1-31 1966 to 7-1 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
George C. ROVETI				7-8-66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
George C. ROVETI				100 N. Broadway Balto 31			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		7-9-66		OAK LAWN Cem.		BALTO. Mo.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 8 1966		E. J. Finkbeiner		Garth Miller - 2334 Jefferson St.			

THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 06938					CERTIFICATE OF DEATH					Registered No. 66 06938				
1. NAME OF DECEASED (Type or Print) John Balzer - SR.					2. DATE AND HOUR OF DEATH 7/6/66 - 10:05 pm.					M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE St. Agnes Apts. Apt 1202 D. B. COUNTY Baltimore County C. CITY OR TOWN (If outside city limits, give county and give township) Baltimore, MD 21229 D. STREET ADDRESS (If rural, give location) 53-00									
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 5/11/75		9. AGE (In years last birthday) 91		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Balt. Transit Co. worker					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Maryland				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Bernard Balzer					14. MOTHER'S MAIDEN NAME Mary Droude				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 213-10-1135					17. INFORMANT Mrs. Alfred Ray ADDRESS 6522 Woodbridge Cir.				
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROSIS + HYPERTENSIVE HEART DISEASE					CAUSE OF DEATH ARTERIOSCLEROSIS + HYPERTENSIVE HEART DISEASE					INTERVAL BETWEEN ONSET AND DEATH YES				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO									
					(B) DUE TO									
					(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) yes			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (this hospital) attended the deceased from 7/1 19 66 to 7/6 19 66 , that (I) (we) last saw the deceased alive on 7/6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.														
23A. SIGNATURE Harold C. Culberson					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 7/7/66				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS 421 Regester Ave Balt									
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE 7-11-66			24C. NAME of CEMETERY or CREMATORY Balto. Nat'l.			24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D. IN HEALTH DEPT. 7-11-66			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR W. J. D. - 4101 Edmondson Ave			ADDRESS					

11/11/72
Merrill
Merrill

W
Merrill
Merrill

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
66 06939					CERTIFICATE OF DEATH					Registered No. 66 06939									
BIRTH NO.										2. DATE AND HOUR OF DEATH									
M.E. CASE NO.										3. PLACE OF DEATH IN BALTIMORE, MARYLAND									
1. NAME OF DECEASED (Type or Print) <i>Harry E. Heiner</i>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Ellicott city</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>63-00</i>									
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>										D. STREET ADDRESS (If rural, give location) <i>392 Orchard ave. Wilton Acres</i>									
5. SEX <i>male</i>		6. RACE <i>white</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>3/12/74</i>		9. AGE (In years last birthday) <i>92</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY?					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10B. KIND OF BUSINESS OR INDUSTRY <i>B & O Railroad</i>									
13. FATHER'S NAME <i>John J. Heiner</i>										14. MOTHER'S MAIDEN NAME <i>Regina mahr</i>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO. <i>705-05-2123A</i>									
17. INFORMANT <i>Mrs. Edwin G. Gail</i>										ADDRESS <i>392 Orchard Av Wilton Acres Ellicott City, Md.</i>									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Low intestinal obstruction 3 days</i>										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO									
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										INTERVAL BETWEEN ONSET AND DEATH									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20A. AUTOPSY? (Yes or No)										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
21C. WHERE DID INJURY OCCUR?										21D. TIME OF INJURY (Month) (Day) (Year) (Hour)									
21E. INJURY OCCURRED										21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE <i>Robert B. McFadden</i>										23B. DATE SIGNED <i>7/7/66</i>									
23C. PHYSICIAN'S NAME (Type) <i>R.B. MCFADDEN</i>										23D. ADDRESS <i>3350 Wilkins Ave</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>										24B. DATE <i>7-11-66</i>									
24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn</i>										24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>									
25A. DATE RECEIVED <i>JUL 8 1966</i>										25B. NAME OF REGISTRAR <i>Robert E. Farley</i>									
25C. FUNERAL DIRECTOR <i>Witzke F. D. - 4101 Edmondson Ave</i>										ADDRESS									

3300 111 111 111

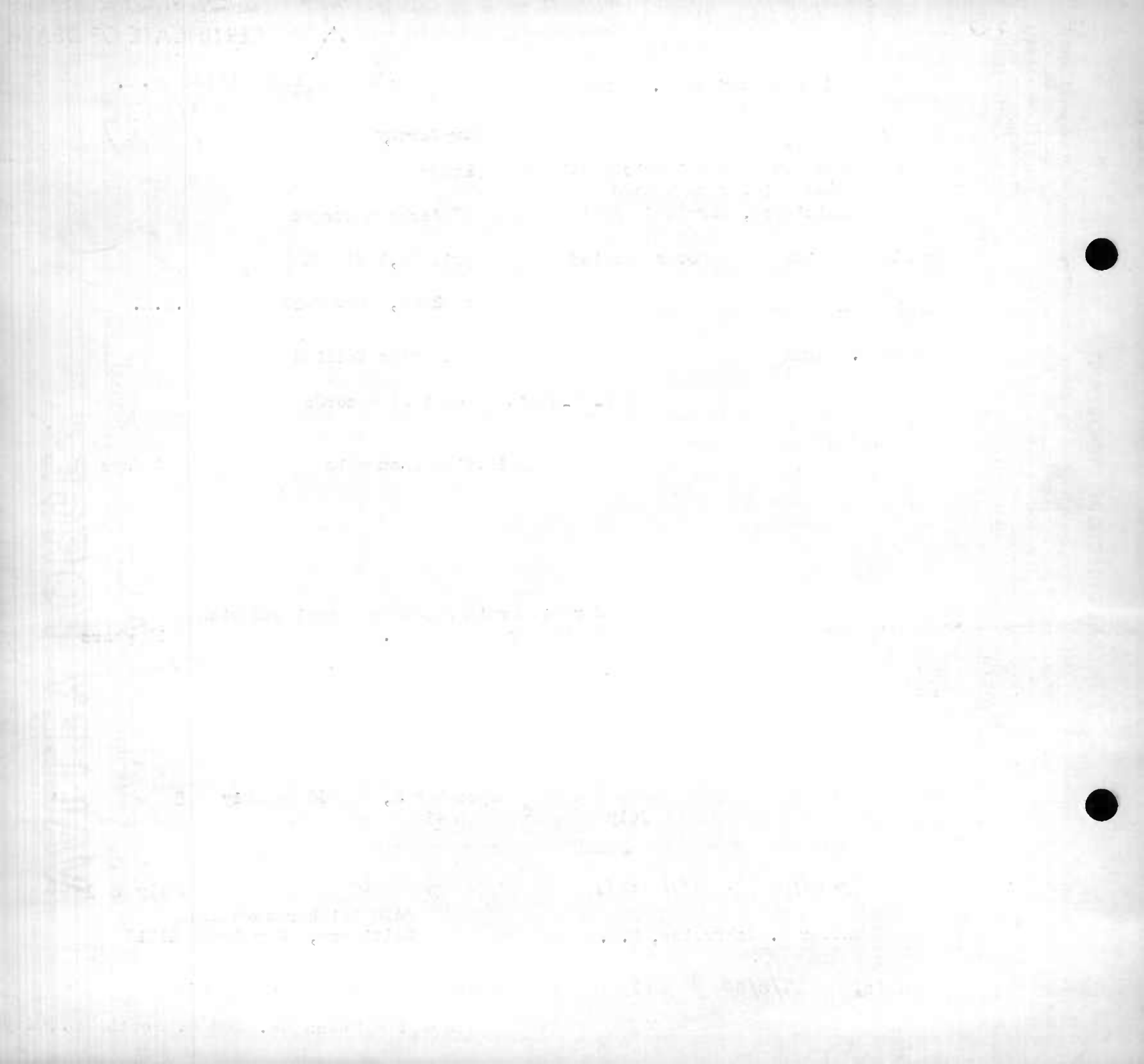
R. J. MCFARREN

Robert B. MCFARREN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 06940	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Miss Katharine M. Moran		2. DATE AND HOUR OF DEATH July 6 1966 12:38 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Seton Psychiatric Institute 6420 Reisterstown Road Baltimore, Maryland 21215		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE New Jersey B. COUNTY K-27 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Paterson D. STREET ADDRESS (If rural, give location) 25 Jackson Street	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH April 25, 1886
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Sales		10B. KIND OF BUSINESS OR INDUSTRY Retail (etc)	
11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Moran		14. MOTHER'S MAIDEN NAME Katherine Collins	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 023-03-5457A	
17. INFORMANT Hospital Records		ADDRESS	
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Chronic brain syndrome associated with senile brain disease.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 8, 1958 to July 6, 1966 and that (I) (we) last saw the deceased alive on July 6, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Walter O. Jahrreiss		23B. DATE SIGNED July 6 1966	
23C. PHYSICIAN'S NAME (Type) Walter O. Jahrreiss, M.D.		23D. ADDRESS 6420 Reisterstown Road Baltimore, Maryland 21215	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/66	
24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Brooklyn, New York	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR Stewart & Mowen Co.		ADDRESS 108 W. North Av., City	



1
B-532

66 06941

BALTIMORE CITY HEALTH DEPARTMENT

66 06941

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE E. BENTZ

2. DATE AND HOUR PRONOUNCED DEAD

July 6, 1966 6:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

603 Wyanoak Avenue Wynoke Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH 1905

Dec. 11, 1906

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Operated Rest Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.A. aa

13. FATHER'S NAME

? Bentz

14. MOTHER'S MAIDEN NAME

Emma Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Leola P. Bentz, 630 Wynoke Ave. Balto.,
Md.

18. E902.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral Injury.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

603 Wyanoak Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 4 '66 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fall from 3d floor porch.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/7/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 9, 1966

23C. NAME of CEMETERY or CREMATORY

St. Paul's United Brethern

23D. LOCATION

(City, town, or county)

Millersville, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 8 1966

R. E. E. Farley

LEONARD J. HUCK, INC., BALTIMORE, Md.

VS153-7/12/66

CERTIFICATE AND DEED

VALENT FORGE

IN THE COUNTY OF

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WARREN L. McCOMAS

2. DATE AND HOUR PRONOUNCED DEAD

July 7, 1966 8:50 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1730 WILMINGTON SQUARE 451 Whitridge Ave.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single (Never Married)

8. DATE OF BIRTH

11/30/1908

9. AGE (In years
last birthday)

57

10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Gardner

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

William Robert McComas

14. MOTHER'S MAIDEN NAME

Susan C. Cotter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215107926

17. INFORMANT

ADDRESS

Mr. Francis X. McComas- 451 Whitridge Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/7/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/12/66

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

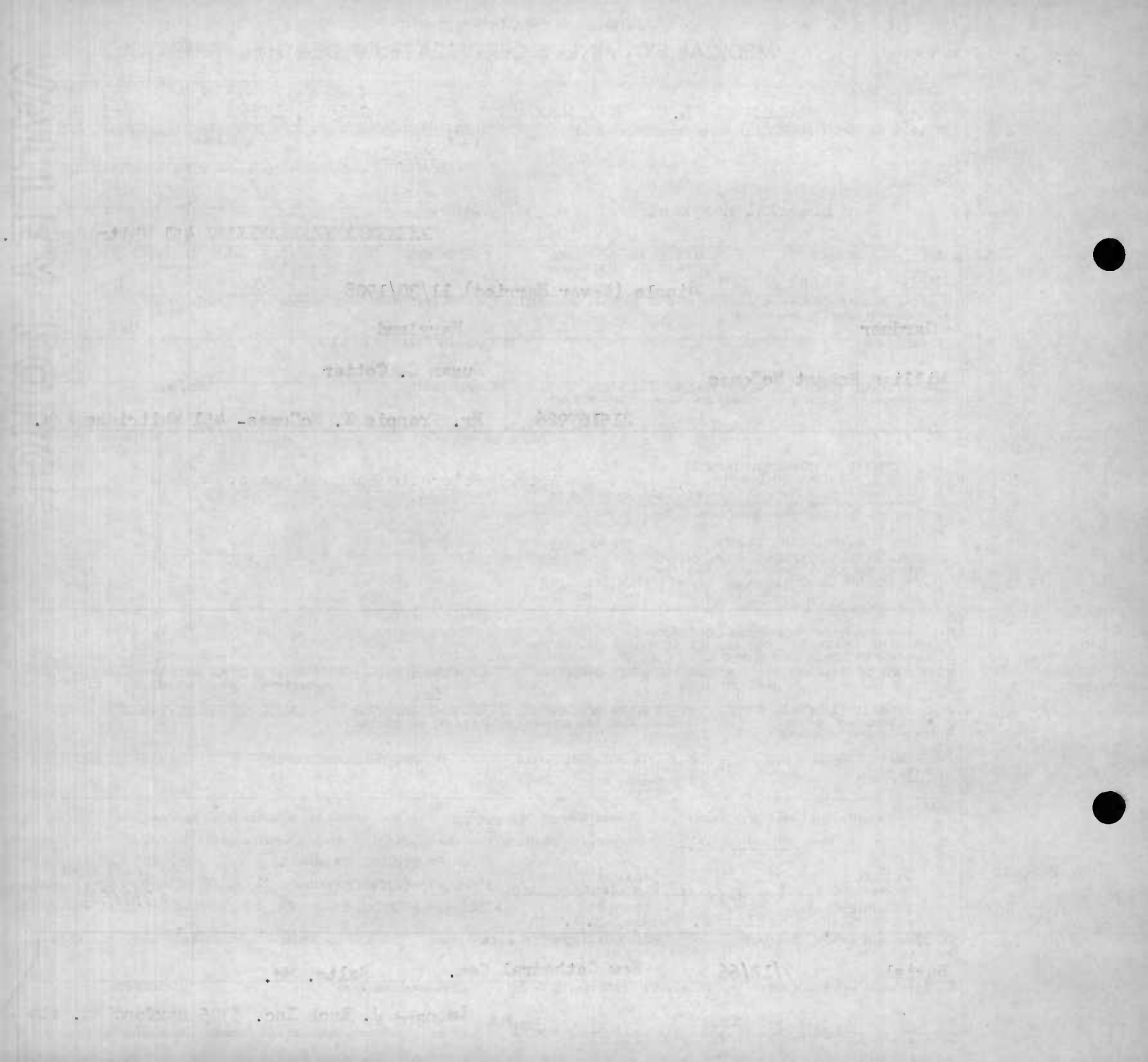
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 8 1966

Leonard J. Ruck Inc. 5305 Harford Rd. #14



1
D-400

66 06943

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66 06943

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
ROBERT E. DEALE, Sr.		July 7, 1966 9:55 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
Johns Hopkins Hospital		Maryland	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore 27-44	
		D. STREET ADDRESS (If rural, give location)	
		5802 Carter Avenue	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Male	White	Married	Feb. 23, 1903
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
Plumber		Hopkins Hosp.	82 63
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
Wilhelmina C. Deale		5802 Carter Ave.	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO Arteriosclerotic Heart Disease.			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) (C)			
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Charles S. Petty, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED			
7/7/66			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
Burial		July 11, 1966	
23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
MORELAND MEMORIAL		Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
JUL 8 1966		Robert E. Finkbeiner	
24C. FUNERAL DIRECTOR		ADDRESS	
LEONARD J. RUCK, INC.		Baltimore, Md.	

WALL REV. 100

THE UNIVERSITY

100

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) HARRY J. SMYTH 2. DATE AND HOUR PRONOUNCED DEAD July 7, 1966 5:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-01

D. STREET ADDRESS (If rural, give location) 1100 Andover Road

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH April 28, 1912 9. AGE (In years last birthday) 54 If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) New Jersey 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME ? Smyth 14. MOTHER'S MAIDEN NAME Carrie Hamburg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 577-14-7974 17. INFORMANT ADDRESS Lauretta May Smyth, 1100 Andover R. Balto.,

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of Penis. DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

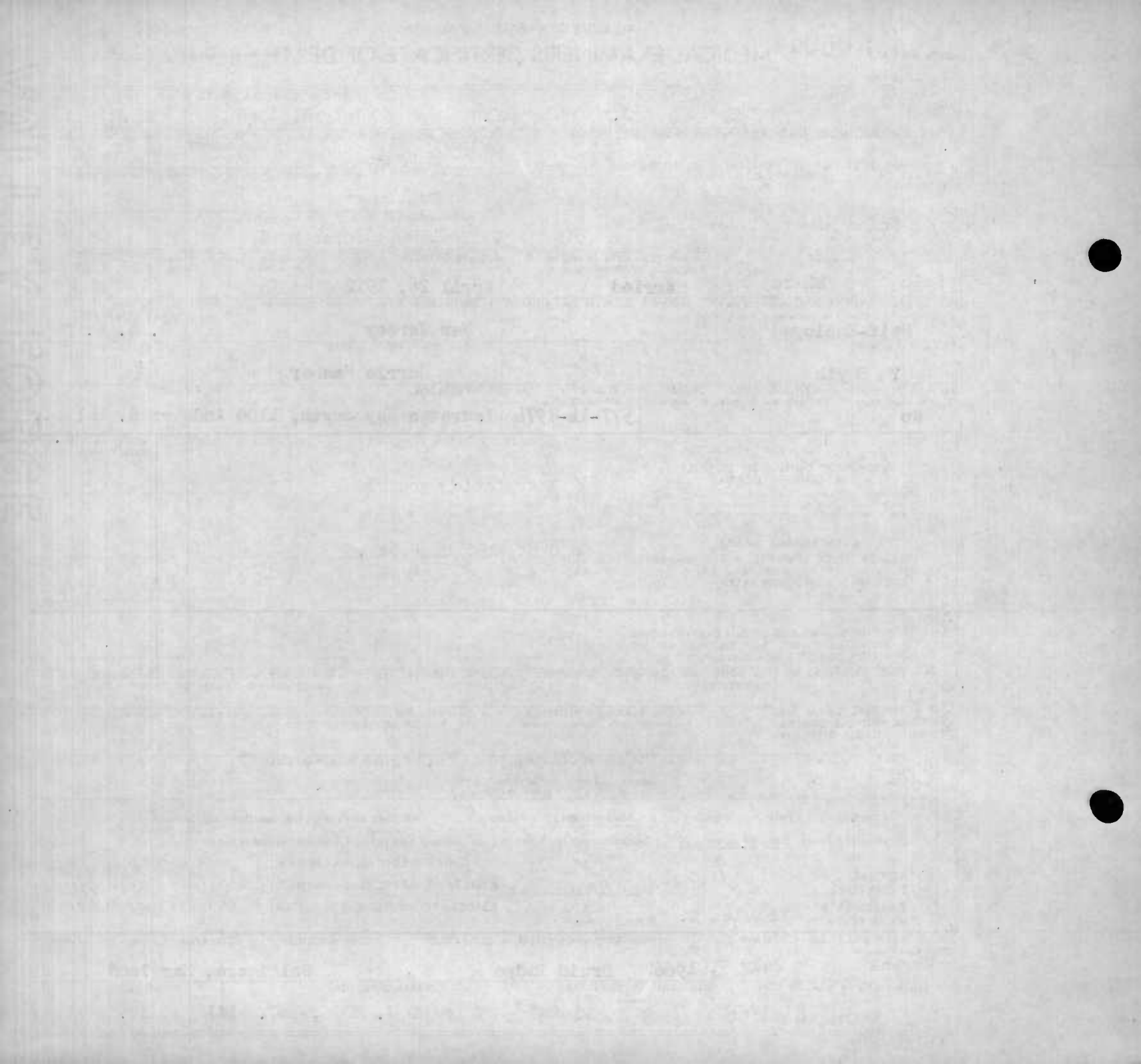
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner
ACTUAL SIGNATURE Charles S. Petty, M.D. CHIEF MEDICAL EXAMINER
EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER
ASSOCIATE MEDICAL EXAMINER
DATE SIGNED 7/7/66

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE July 9, 1966 23C. NAME of CEMETERY or CREMATORY Druid Ridge 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. JUL 8 1966 24B. NAME OF REGISTRAR Robert E. Farley, M.D. 24C. FUNERAL DIRECTOR ADDRESS LEONARD J. RUCK, INC. BALTO., MD.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 66 06945					CERTIFICATE OF DEATH					Registered No. 66 06945						
1. NAME OF DECEASED (Type or Print) <i>Joseph J. Dicke</i>					2. DATE AND HOUR OF DEATH <i>July 6, 1966</i> <i>7.30 P.</i> M.											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>35 Church Home Hospital</i>					A. STATE <i>Md.</i>					B. COUNTY						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i>					<i>27-18</i>						
					D. STREET ADDRESS (If rural, give location) <i>3516 W. Garrison Avenue</i>											
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED <i>Widowed</i>		8. DATE OF BIRTH <i>7/4/1894</i>		9. AGE (In years lost birthday) <i>72</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Vitus Dicke</i>					14. MOTHER'S MAIDEN NAME <i>Dorothea Michel</i>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <i>214368979</i>					17. INFORMANT <i>Mr. Joseph Ackermann, 2919 E. Joppa Rd</i>					ADDRESS	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>myocardial infarction</i> (B) <i>aspiration pneumonia</i> (C) <i>arteriosclerotic cardiac vascular disease</i>					INTERVAL BETWEEN ONSET AND DEATH <i>probably 1 day</i> <i>Immediate</i> <i>since 1959</i>						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<i>Coronary artery insufficiency</i>					<i>3 mos.</i>						
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <i>July 1966</i> to <i>July 6, 1966</i> , that (I) (we) last saw the deceased alive on <i>April 23, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE <i>Milton B. Kress</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <i>7/8/66</i>						
23C. PHYSICIAN'S NAME (Type) <i>MILTON B. KRESS</i>					M.D. <i>Medical arts Bldg. Balto. Md</i>					23D. ADDRESS						
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>7/11/66</i>					24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>					24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1966</i>					25B. NAME OF REGISTRAR <i>Robert E. Farber</i>					25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc., Balto., Md.</i>					ADDRESS <i>21214</i>	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06946		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06946	
M.E. CASE NO.		DATE AND HOUR OF DEATH		JULY 7, 1966 1:00 P.M.	
1. NAME OF DECEASED (Type or Print) Vincenzo Del Giudice Vincenzo Del Giudice		2. PLACE OF DEATH IN BALTIMORE, MARYLAND			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE Maryland B. COUNTY Baltimore #18 9-06			
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH Oct. 28, 1883		9. AGE (In years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tailor	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ginardo Del Giudice	
14. MOTHER'S MAIDEN NAME Fannie Valentine		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-9599	
17. INFORMANT Mrs. Marianna DelGiudice		18. ADDRESS (Same)			
19. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Cerebral hemorrhage & DUE TO (B) Arterio sclerotic cerebro vascular disease DUE TO (C) Senility		3-4 d. 10 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1955 to July 7, 1966, and that (I) (we) last saw the deceased alive on July 7, 1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theodore S. Graziano		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/7/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Theo. J. Graziano		2802 Harford Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/11/66		Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county)		24E. STATE			
Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 8 1966		Robert E. Tarkenton		Leonard J. Ruck Inc. 5305 Harford Rd.	

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UNITED STATES DEPARTMENT OF AGRICULTURE

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66 06947

BALTIMORE CITY HEALTH DEPARTMENT

66 06947

BIRTH NO. 65-24006 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) DARRIN S. MURRAY 2. DATE AND HOUR PRONOUNCED DEAD 7-5-66 3:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOUR HOSPITAL - DOA C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1800 W. Fayette Street

5. SEX Male 6. RACE Colored 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) 8. DATE OF BIRTH 9. AGE (In years last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Malnutrition and dehydration DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Encephalocele (by history) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUDIGER BREITENECKER, M.D.

CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 7-6-66

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 7/8/1966 23C. NAME of CEMETERY or CREMATORY Mt. Calvary 23D. LOCATION (City, town, or county) (State) Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT. JUL 8 1966 24B. NAME OF REGISTRAR Robert E. Fairbank 24C. FUNERAL DIRECTOR 24D. ADDRESS 1712 W. W. Work

WALLLEY POLICE

OFFICE OF THE SHERIFF

CLERK OF THE COURT

DEPUTY SHERIFF

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66 06948

BALTIMORE CITY HEALTH DEPARTMENT

66 06948

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Minor Turnage

2. DATE AND HOUR PRONOUNCED DEAD

7/5/66 8:25 a. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1208 Jefferson Ct.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

9/7/1913

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

Chester S. C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jim Turnage

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

218-03-2647

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/5/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/8/66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

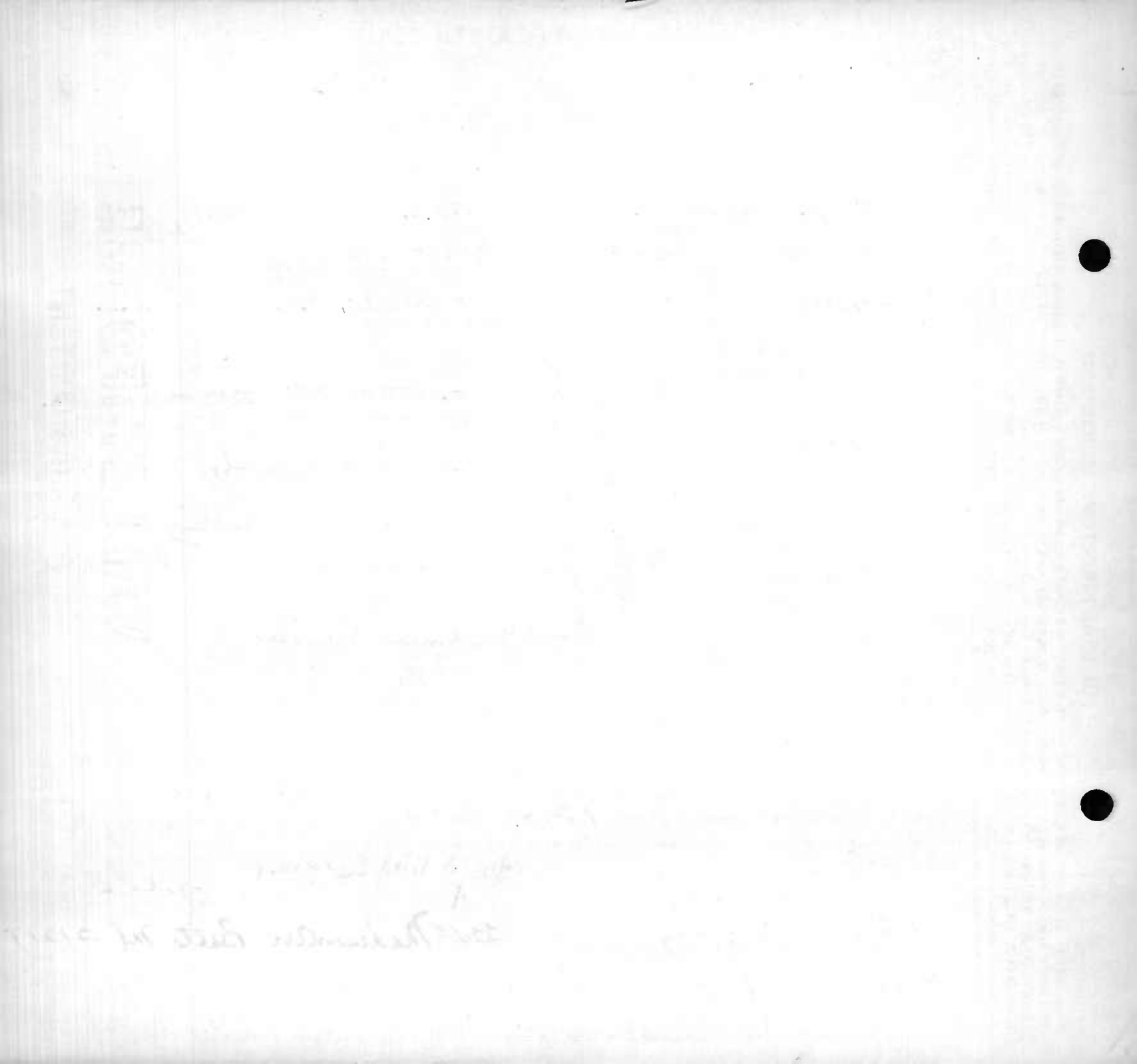
WALLLEY POLICE

IN COUNTY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06949		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06949	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mary D. Cook		2. DATE AND HOUR OF DEATH 7-5-66 8:00 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 770 W. SARATOGA ST.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 770 W. SARATOGA STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH Sept 1898	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LYONSVILLE, S.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME THOMAS DUNCAN			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Eugene Cook 2242 Madison Ave.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Acute Cardiovascular Arteriosclerotic Cordic Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 6 months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Exophthalmic Goiter					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/31 19 65 to 12-3- 19 65 , that (I) (we) last saw the deceased alive on 12/31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. Brashaw Higgins		M.D. Attending Phys. Examined		23B. DATE SIGNED 7-6-66	
23C. PHYSICIAN'S NAME (Type) I. Brashaw Higgins		23D. ADDRESS M.D. 5343 Madison Ave. Balt. Md. 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7-9-66	24C. NAME OF CEMETERY or CREMATORY MT. AUBURN		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS MORTON + Dye IT 1701 LAURENS ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 06950	
BIRTH NO. 66 06950		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mary McKenzie		2. DATE AND HOUR OF DEATH July 7, 1966 12:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3608 Grantley Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6-15-23	9. AGE (In years lost birthday) 43	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Richard Peacock				14. MOTHER'S MAIDEN NAME Ella Powell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Elias McKenzie		
					ADDRESS 3608 Grantley Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Large gluteal lesion				INTERVAL BETWEEN ONSET AND DEATH From 6-13-66			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Addison's disease				to 7-7-66			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Abscess abdominal wall							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 13, 1966 to July 7, 1966 , that (I) (we) last saw the deceased alive on July 7, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 7, 1966	
23C. PHYSICIAN'S NAME (Type) Ata Amini				23D. ADDRESS M.D. 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-12-66		24C. NAME OF CEMETERY OR CREMATORY mt. Olive Cemetery		24D. LOCATION (City, town, or county) (State) Whitesville, North Carolina	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR JUL 8 1966		25C. FUNERAL DIRECTOR Morton - Ruppel		ADDRESS	

0-15-28

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH										Registered No.	
<div style="display: flex; justify-content: space-between;"> W-426 66 06951 66 06951 </div>											
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Ella DORA Wells</i> </div> <div> 2. DATE AND HOUR OF DEATH <i>July 4, 1966 112 Noon</i> M. </div> </div>											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION <i>Bar-wil-Ba Convalescent</i> </div> <div> (If not in hospital or institution, give street address or location) </div> </div>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE <i>Md.</i> </div> <div> B. COUNTY <i>Baltimore</i> </div> </div>					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Perry Hall</i>					
						D. STREET ADDRESS (If rural, give location) <i>Box 171 - Forge Road</i>					
5. SEX <i>F</i>		6. RACE <i>Colored</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>		8. DATE OF BIRTH <i>9-18-88</i>		9. AGE (In years last birthday) <i>77</i>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>											
13. FATHER'S NAME <i>John Myers</i>						14. MOTHER'S MAIDEN NAME <i>Mary Johnson</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Lena M. Demby, Box 171, Forge Rd, Perry Hall</i>				ADDRESS <i>Md.</i>	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. </div> <div> (A) DUE TO <i>Generalized arteriosclerosis</i> </div> </div>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>II</i>											
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1-15-</i> <i>1965</i> to <i>7-4-</i> <i>1966</i> that (I) (we) last saw the deceased alive on <i>7-2-</i> <i>1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>C.R. Campbell</i>								23B. DATE SIGNED <i>7-4-66</i>			
23C. PHYSICIAN'S NAME (Type) <i>C.R. Campbell</i>								23D. ADDRESS <i>1618 W. North Ave. Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>July 7, 1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Asbury Methodist Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>Lorely Balto. Co. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1966</i>				25B. NAME OF REGISTRAR <i>Robert E. Farber</i>				25C. FUNERAL DIRECTOR <i>Howard K. McComas & Son, Abingdon, Md.</i>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06952				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 06952	
1. NAME OF DECEASED (Type or Print) PAULINE E. SIEGEL				2. DATE AND HOUR OF DEATH 7/5/66 1225 M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2120 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12-02 D. STREET ADDRESS (If rural, give location) 39TH & UNIV. PKWY					
5. SEX F	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE		8. DATE OF BIRTH 6/26/84	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME FRANZ J. SIEGEL				14. MOTHER'S MAIDEN NAME Caroline Eckhardt CAROLINE ECKHARDT					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 316-46-4291		17. INFORMANT MRS. CLARA M. PLITT		ADDRESS 518 OVERBROOK RD. (21212)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO MULTIPLE CVA CEREBRAL VASCULAR ACCIDENT (B) DUE TO FRACTURE OF (R) HUMERUS (C) _____				INTERVAL BETWEEN ONSET AND DEATH 7/3-7/5 6/28-7/5	
19A. DATE OF OPERATION 6/28/66				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NORTH Broadview Apts					
21D. TIME OF INJURY (APPROX.) 6 28 66 10PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FALL					
22. I certify that (I) (this hospital) attended the deceased from 6/28/66 19 to 7/5 19 66 . that (I) (we) last saw the deceased alive on 7/5 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
23A. SIGNATURE J. H. Hitzrot				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/5/66			
23C. PHYSICIAN'S NAME (Type) J. H. HITZROT		dr. J. H. HITZROT		23D. ADDRESS union memorial hospital 6000. Bluechase Ave.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/1966		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto. 12, Md.			

370 x 2000 ft. (approx)

1/2 in 1/2 in

2000 ft. (approx)

2000 ft.

~~1000 ft. (approx)~~

TRANSVERSE
SECTION
OF
ROAD

1/2 in

1/2 in
1/2 in

2000 ft.

1/2 in

1/2 in

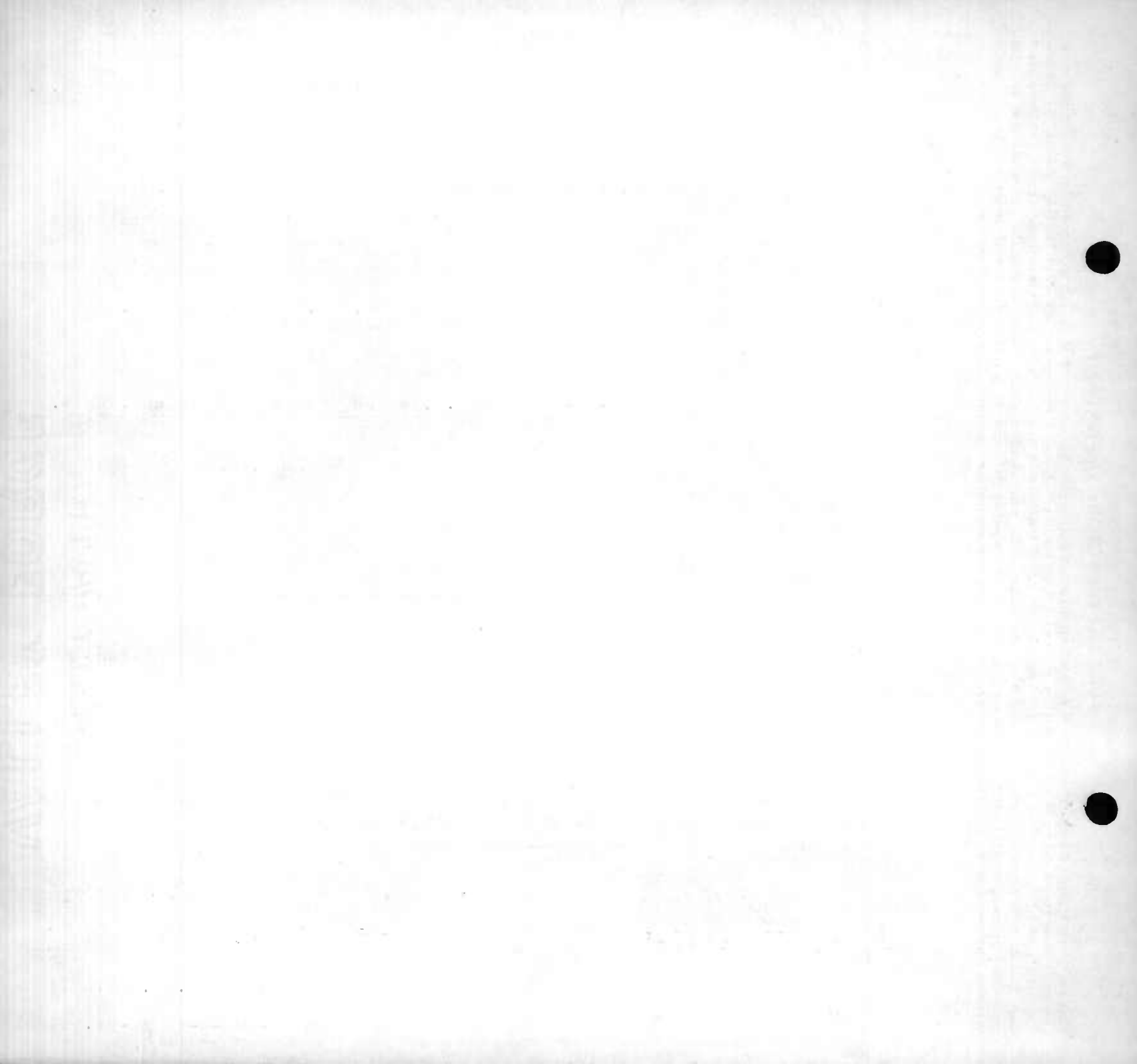
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FUNERAL DIRECTOR: IMPORTANT

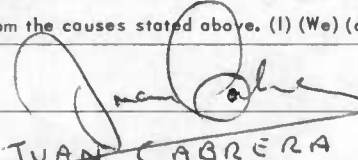
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. _____	
BIRTH NO. 66 06953		CERTIFICATE OF DEATH		66 06953	
1. NAME OF DECEASED (Type or Print) Charles Matthew Everhart			2. DATE AND HOUR OF DEATH July-7-1966 1-7-A.M.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) died at his residence			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-09		
5. SEX Male			6. RACE White		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed			8. DATE OF BIRTH About 1885		
9. AGE (In years last birthday) about 80			10. AGE (In years last birthday) about 80		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired			10B. KIND OF BUSINESS OR INDUSTRY Salesman		
11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Charles Everhart			14. MOTHER'S MAIDEN NAME Caroline G. Miller		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 215-12-4979		
17. INFORMANT Chas. E. Torsch (nephew)			ADDRESS Cleveland, Ohio.		
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) arteriosclerotic Cardio Vascular Disease DUE TO (B) _____ DUE TO (C) _____		
19A. DATE OF OPERATION June 6, 1956			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED relax		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) No		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? No		
22. I certify that (I) (this hospital) attended the deceased from June 6, 1956 to June 7, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE James E. White			23B. DATE SIGNED July 8, 1966		
23C. PHYSICIAN'S NAME (Type) James E. White			23D. ADDRESS 5214 Harford Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE July-9-66		24C. NAME of CEMETERY or CREMATORY Lorraine	
24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co. (21207)		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co-108-W-North-Av. 21201			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06954	
BIRTH NO. 66 06954		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 7-7-66 6:00A M.	
1. NAME OF DECEASED (Type or Print) LAYNOR, CATHERINE RIGG			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY HOWARD	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLCOTT CITY	
		D. STREET ADDRESS (If rural, give location) 17 SYBERT DRIVE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12-4-13
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 52
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN RIGG		14. MOTHER'S MAIDEN NAME FRANCES KILBURN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NR NO		16. SOCIAL SECURITY NO. 173-10-6586	
		17. INFORMANT ADDRESS ST. AGNES RECORDS - CATON & WILKENS AVE MR. ROGER V. LAYNOR, 17 SYBERT DRIVE, ELLCOTT CITY	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 156.2.1 METASTATIC CARCINOMA OF LIVER.		CAUSE OF DEATH (A) METASTATIC CARCINOMA OF LIVER. (B) (C) 	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 14 1966 to JULY 7 1966 , that (I) (we) last saw the deceased alive on JULY 7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED 7/7/66	
23C. PHYSICIAN'S NAME (Type) JUAN CABRERA		23D. ADDRESS CATON & WILKENS AVE BALD. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-9-66	
24C. NAME of CEMETERY or CREMATORY GRACE EPISCOPAL CEMETERY		24D. LOCATION (City, town, or county) (State) HOWARD COUNTY, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR JUL 11 1966 R. E. Farley, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVENUE	

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UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06955		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06955	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Leo Bourgeois</i>		2. DATE AND HOUR OF DEATH <i>6/24/66 17:20 P. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33 THE JOHNS HOPKINS HOSPITAL</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 1-03</i> D. STREET ADDRESS (If rural, give location) <i>601 S. BRADFORD ST.</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWER</i>	8. DATE OF BIRTH <i>9-16-05</i>	9. AGE (In years last birthday) <i>60</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>NAPOLEON</i>		14. MOTHER'S MAIDEN NAME <i>DIANA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>liver failure</i> <i>Alcohol</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>20 yrs.</i>	
19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CERTIFICATION APPROVED BY <i>[Signature]</i> CHIEF OF ASST. MEDICAL EXAMINER, U.D.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-14-66</i> to <i>6-24-66</i> and that (I) (we) lost saw the deceased alive on <i>6-24-66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Ashtley T. Harse</i> 23C. PHYSICIAN'S NAME (Type) <i>ASHTLEY T. HARSE</i>			
23B. DATE SIGNED <i>6-24-66</i>		23D. ADDRESS <i>JOHNS HOPKINS MEDICAL SCHOOL</i>			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <i>JUN 30 1966</i>		24C. NAME OF CEMETERY OR CREMATORY <i>JOHNS HOPKINS MEDICAL SCHOOL</i>		24D. LOCATION (City, town, or county) (State) <i>BCHD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 11 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR ADDRESS <i>MORTUARY SERVICE</i>	

B-652

66 06956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

66 06956

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BURNS, George

2. DATE AND HOUR OF DEATH

6/15/66

5:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospital
4940 Eastern Avenue, Baltimore, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

12-03

D. STREET ADDRESS (If rural, give location)

2405 Barclay St.

21218 007

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

12-26-1917

9. AGE (In years
lost birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

US

13. FATHER'S NAME

Elijna

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue

21224

18. 422.141322.2
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Congestive heart failure
probably pulmonary edema

(B) DUE TO

arteriosclerotic cardiovascular
disease

(C)

INTERVAL BETWEEN
ONSET AND DEATH

3 weeks

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Alcoholism

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1:45 am 6/15 1966 to 5:15 am 6/15 1966,
that (I) (we) last saw the deceased alive on 6/15 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did not) view the body after death.

23A. SIGNATURE

Philip Horowitz

M.D.

Attending
Phys.Med.
Director ☒Staff
Phys. ☐

23B. DATE SIGNED

6/15/66

23C. PHYSICIAN'S
NAME (Type)

Philip Horowitz

M.D.

23D. ADDRESS
4940 Eastern Avenue, Baltimore, Maryland24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

JUN 28 1966

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

City, town, or county

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 11 1966

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR

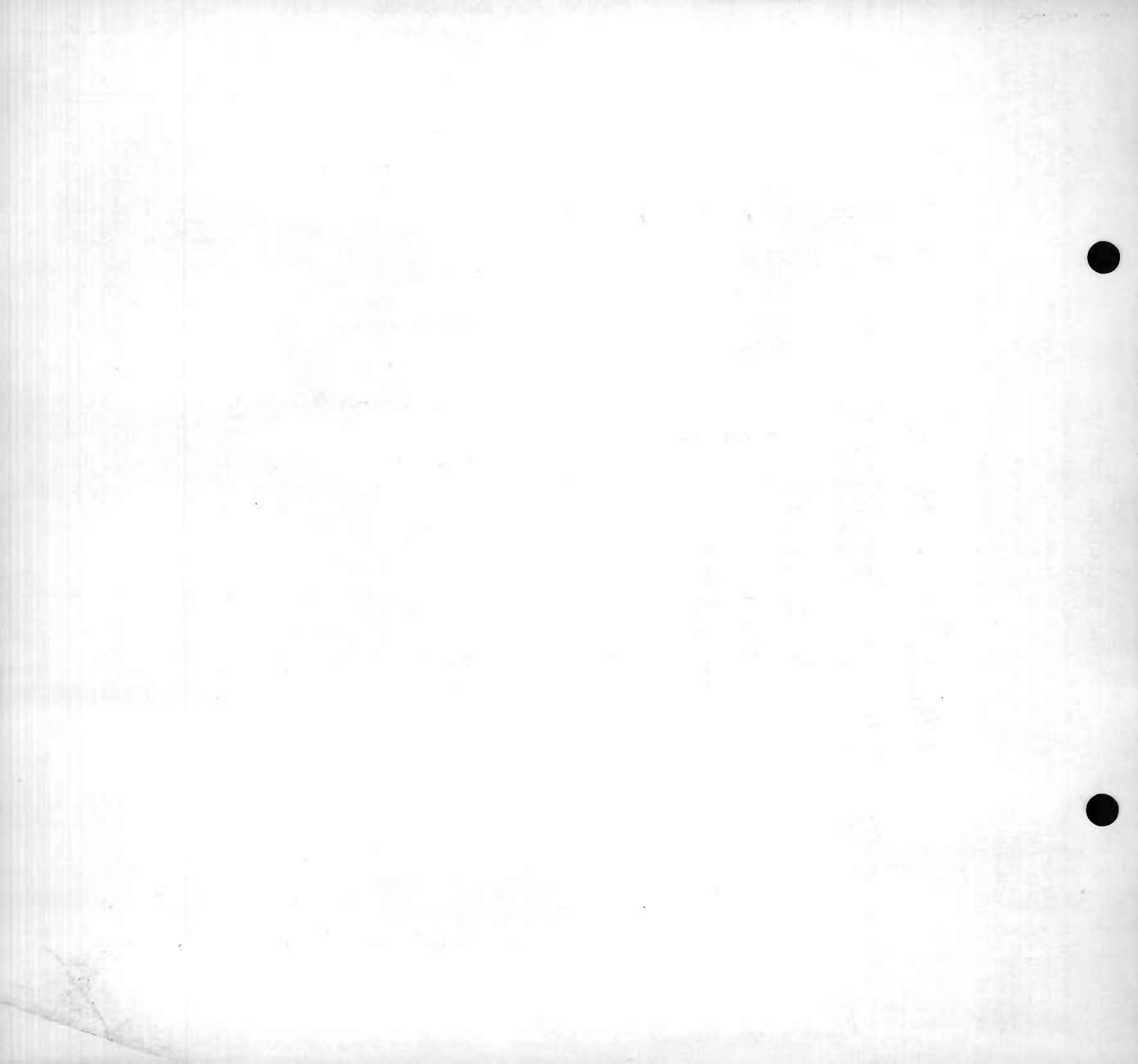
ADDRESS

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

FUNERAL DIRECTOR: IMPORTANT

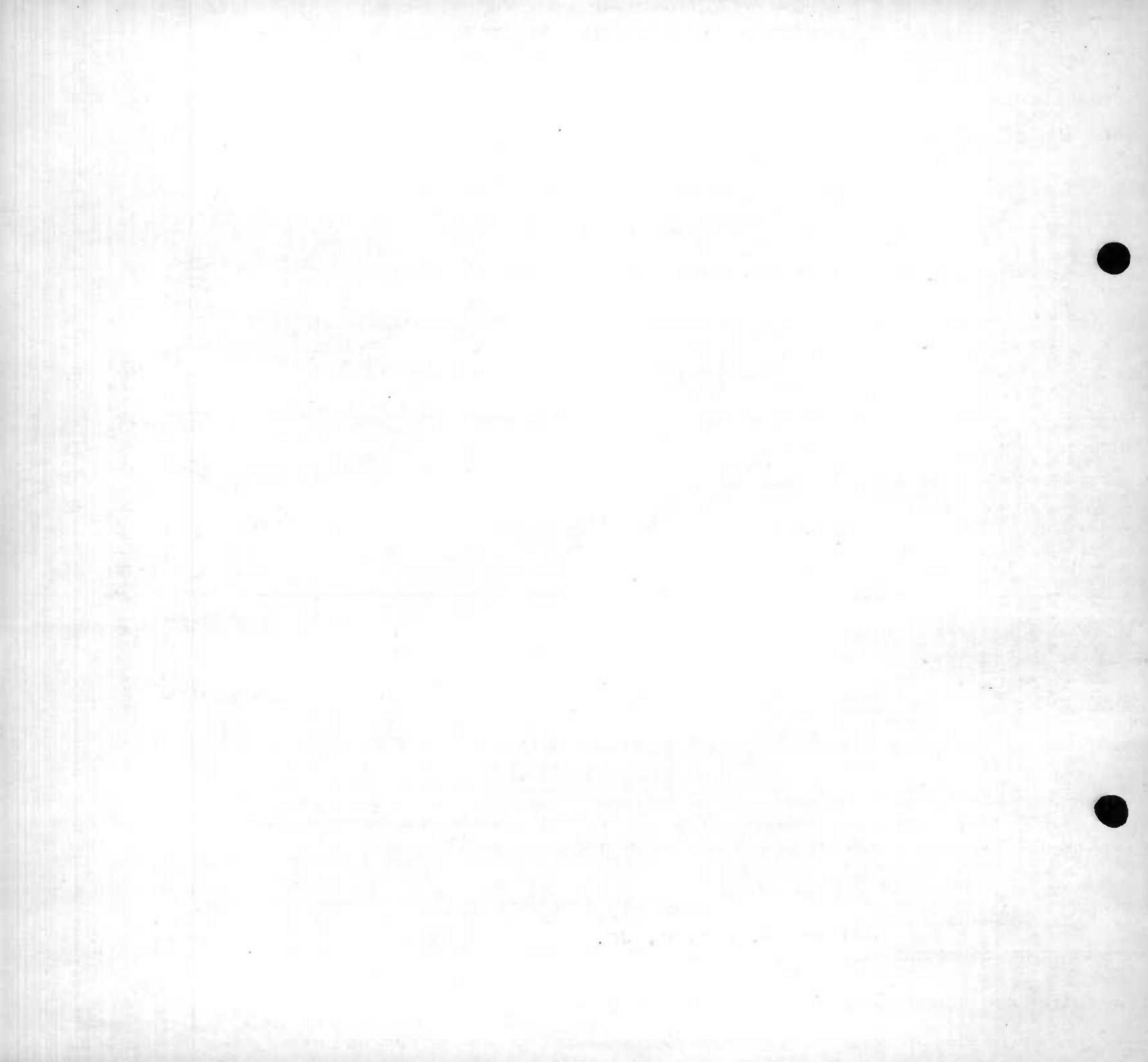
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06957		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06957	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) FONDA, OLIVE MAY ALLEN			2. DATE AND HOUR OF DEATH 6-23-66 1 11:45 PM.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 38 University of Maryland Hospital			A. STATE Maryland B. COUNTY 99		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Jessup 52-00		
			D. STREET ADDRESS (If rural, give location) Correctional Inst. for Women		
5. SEX F	6. RACE cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 12-10-11	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME David Allen			14. MOTHER'S MAIDEN NAME Julia DeVise		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Hospital chart		ADDRESS
18. 581.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HEPATIC CIRRHOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC HEPATITIS			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6-15-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Portal Hypertension		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-26 19 66 to 6-23 19 66 , that (I) (we) lost saw the deceased alive on 4-26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nelson S. Keeler, Jr.				23B. DATE SIGNED 6-23-66	
23C. PHYSICIAN'S NAME (Type) Nelson S. Keeler, Jr.				23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL	
24A. BURIAL CREMATION, REMOVAL (Specify) JUL 1 1966		24B. DATE JUL 1 1966		24C. NAME OF CEMETERY or CREMATORY Robert E. Farley, MA	
24D. LOCATION JUL 11 1966		24E. NAME OF REGISTRAR Robert E. Farley, MA		24F. FUNERAL DIRECTOR MORTUARY SERVICE & CHD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
66 06958		66 06958		66 06958	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
				LOGAN, MAGGIE V	
2. DATE AND HOUR OF DEATH		JULY 5, 1966 4:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
42 SINAI HOSPITAL OF BALTIMORE, INC.		BALTIMORE, MARYLAND 28-02			
5. SEX F		6. RACE N		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	
8. DATE OF BIRTH JUNE 23, 1904		9. AGE (In years last birthday) 62		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Clarence Cook		14. MOTHER'S MAIDEN NAME Frances Crawley			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT 3913 Dolfield Avenue Mrs. Doris Segal	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
CORONARY ARTERY DISEASE		(A) DUE TO			
HYPERTENSION		(B) DUE TO			
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/5/66 to 7/5/66, that (I) (we) last saw the deceased alive on 7/5/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hyman Greenfield		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/5/66	
23C. PHYSICIAN'S NAME (Type) Hyman Greenfield		23D. ADDRESS Sinai Hospital Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-66		24C. NAME of CEMETERY or CREMATORY Carver Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR 1735 Harford Ave. Marshall W. Jones, Jr.	

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20240

UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

FUNERAL DIRECTOR: IMPORTANT

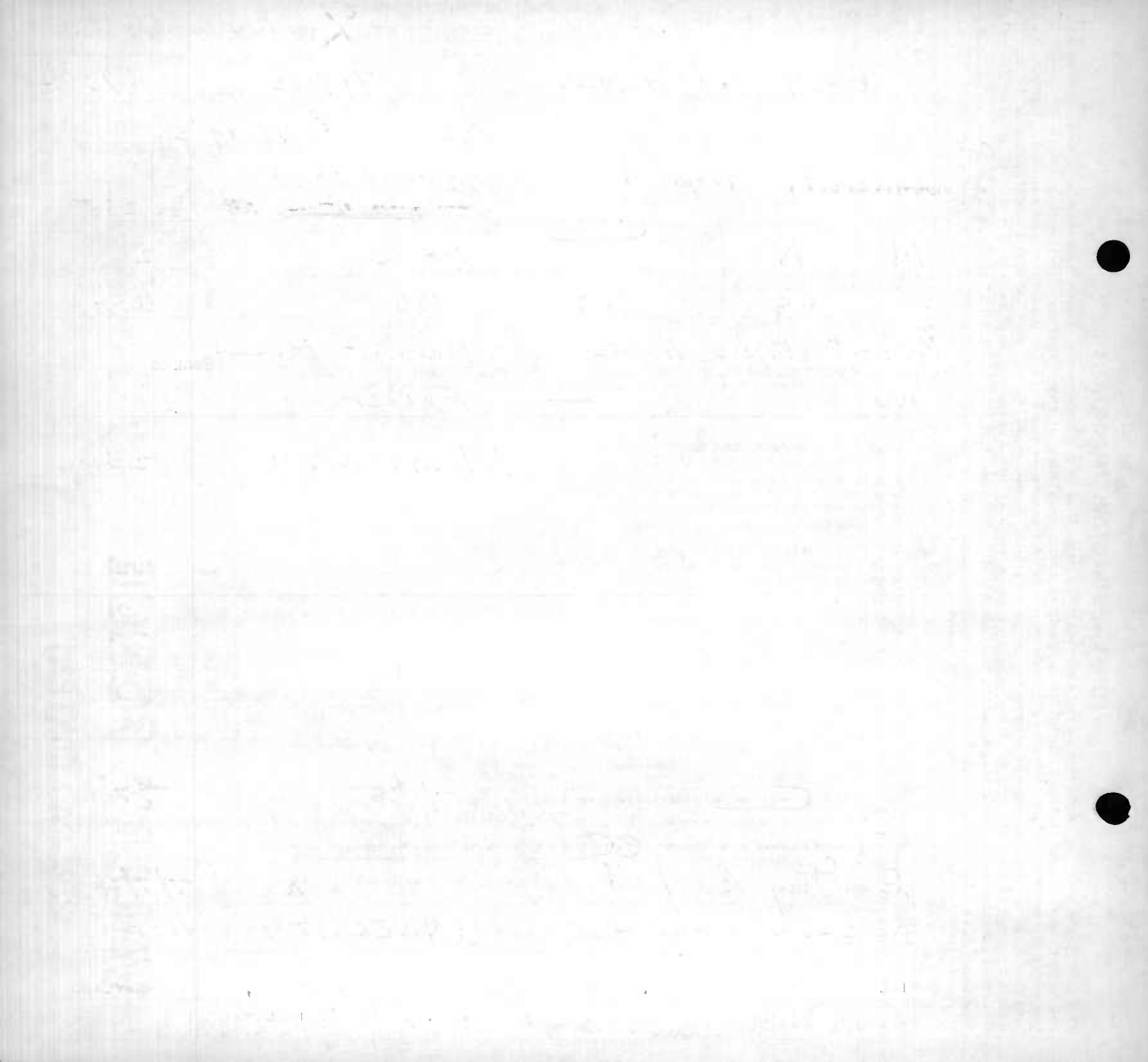
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06959	
M.E. CASE NO.		1. NAME OF DECEASED GARATH BRETNEY W.		2. DATE AND HOUR OF DEATH 6-24-66 11:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND GARATH		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 19-03	
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSP.		D. STREET ADDRESS (If rural, give location) 1407 W. HOLLINS ST		E. CITY OR TOWN (If outside city limits, write RURAL and give township)	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) TERMINAL BRONCHOPNEUMONIA (B) SUBTOTAL GASTRECTOMY (C) MULTIPLE GASTRIC ULCER Arteriosclerotic Cardiovascular Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6-18-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED MULTIPLE GASTRIC ULCER		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 8 1966 to June 24 1966 , that (I) (we) last saw the deceased alive on June 24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wilfredo M. Mediano		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-24-66	
23C. PHYSICIAN'S NAME (Type) WILFREDO M. MEDIANO		23D. ADDRESS FRANKLIN SQUARE HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE JUL 1 1966		24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966		25B. NAME OF REGISTRAR Robt E. Farber		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06960	
BIRTH NO. 66 06960		CERTIFICATE OF DEATH	
M.E. CASE NO.		DATE AND HOUR OF DEATH 7/7/66 10³⁰ A.M.	
1. NAME OF DECEASED (Type or Print) BABY BOY HUMES		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital		A. STATE Md. B. COUNTY St. Mary's.	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Leonard town.	
		D. STREET ADDRESS (If rural, give location) Lexington Park Rt Box 235	
5. SEX M	6. RACE N	7. MARRIED, <u>NEVER MARRIED</u> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 7/5/66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10B. KIND OF BUSINESS OR INDUSTRY NA	9. AGE (In years lost birthday) 2
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Moses Humes		14. MOTHER'S MAIDEN NAME Margaret M. — SWALES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
		17. INFORMANT Father	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) IMMATURITY		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) <u>this hospital</u> attended the deceased from 7/6/66 19 to 7/7/66 19, that (I) <u>we</u> lost saw the deceased alive on 7/7/66 19 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.			
23A. SIGNATURE D. Gary Benfield		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 7/7/66
23C. PHYSICIAN'S NAME (Type) D. GARY BENFIELD		23D. ADDRESS UNIVERSITY HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7/9/66	24C. NAME OF CEMETERY or CREMATORY ST. JOHNS CEMETERY	24D. LOCATION (City, town, or county) (State) HOLLYWOOD, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966		25B. NAME OF REGISTRAR Robert E. Tarkenton	25C. FUNERAL DIRECTOR ADDRESS W. CLARKE MATTINGLEY Mattingley Funeral Home - Leonard town Md.



FUNERAL DIRECTOR: IMPORTANT

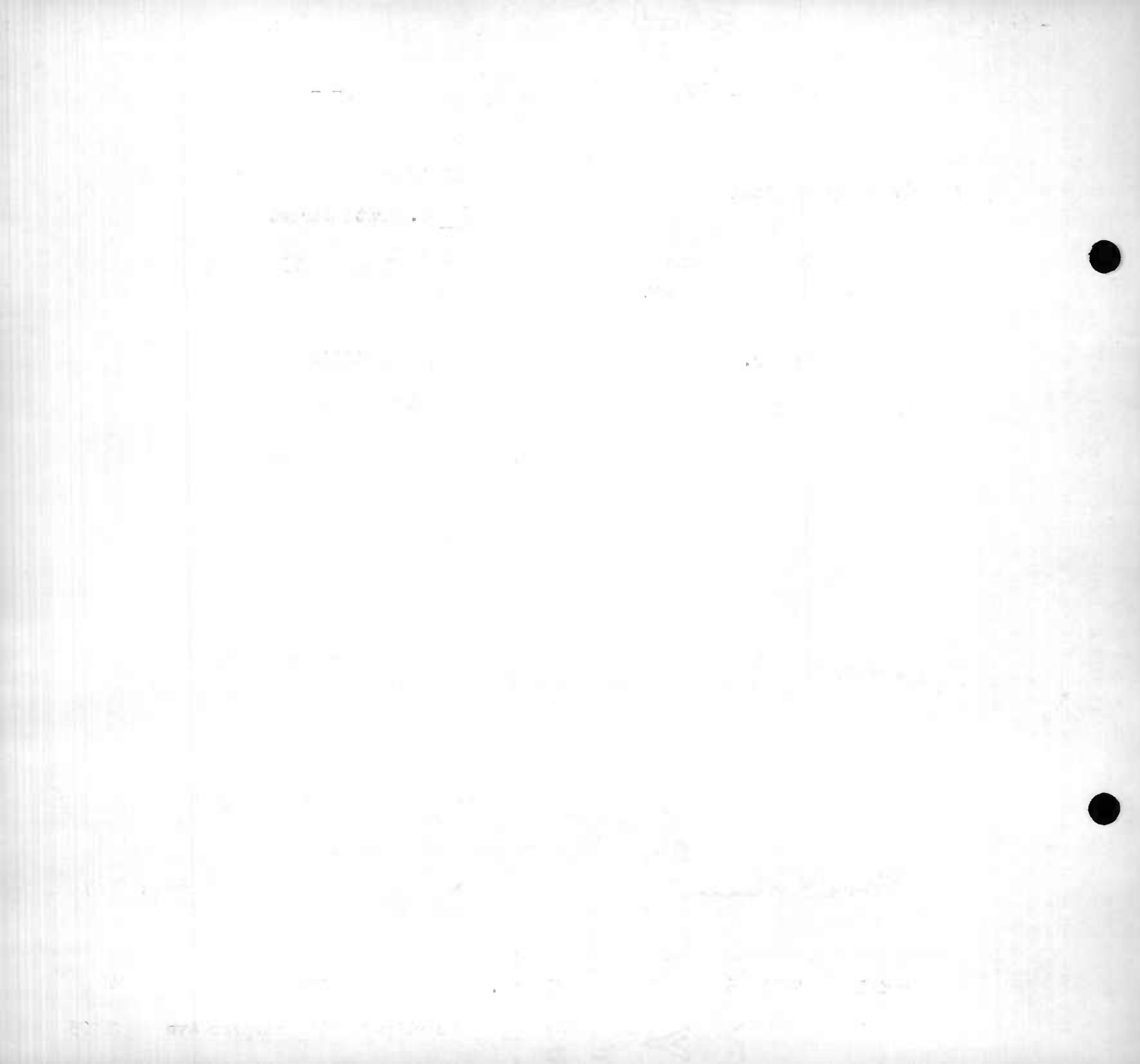
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department		Certificate of Death		Registered No. 66 06961	
BIRTH NO. 66 06961		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) MEDLEY Baby Boy		2. DATE AND HOUR OF DEATH 10 ³⁸ pm - 7/6/66		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS JOPKINS HOSPITAL		A. STATE MARYLAND B. COUNTY ST. MARYS			
5. SEX MALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	
8. DATE OF BIRTH 7-5-66		9. AGE (In years last birthday) 1		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LEONARDTOWN, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH MEDLEY		14. MOTHER'S MAIDEN NAME MARY LORETTA Winters	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother same as # 4	
18. 340.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Gram negative sepsis DUE TO			
ANTECEDENT CAUSES		(B) Perforated stomach DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7/5/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Stomach		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/5 1966 to 7/6 1966, that (I) (we) last saw the deceased alive on 7/6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth E. Berns		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/6/66	
23C. PHYSICIAN'S NAME (Type) KENNETH E. BERNs		23D. ADDRESS M.D. Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/9/66		24C. NAME OF CEMETERY or CREMATORY ST. JOSEPHS CEMETERY	
24D. LOCATION (City, town, or county) MORGANZA,		(State) MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR W. CLARKE MATTINGLEY	
		ADDRESS LEONARDTOWN, MD.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06962</u>	
BIRTH NO.		66 06962		CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print)			7-5-66		
Joseph Olevich			M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
University Hospital			Md		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			6 W. Pratt Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Married	10 23 1892	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Recorder		city	Md		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph Olevich Sr.			Grace Jastitis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
Yes		WWI	Algard Olevich		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) Carcinoma Prostate Gland.		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Feb 14, 1966		Carcinoma Prostate Gland	no		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
		While At Work <input type="checkbox"/> At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Feb 12, 1966 to July 5, 1966, that (I) (we) last saw the deceased alive on July 5, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED
George E. Shannon					July 7, 1966
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
			M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)	(State)
Burial	7/11/66	Balto Nat'l Cem.		Balto	Md
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS		
JUL 11 1966	Robert E. Farkany		McGully FH 237 Patapsco Ave 21225		



FUNERAL DIRECTOR: IMPORTANT

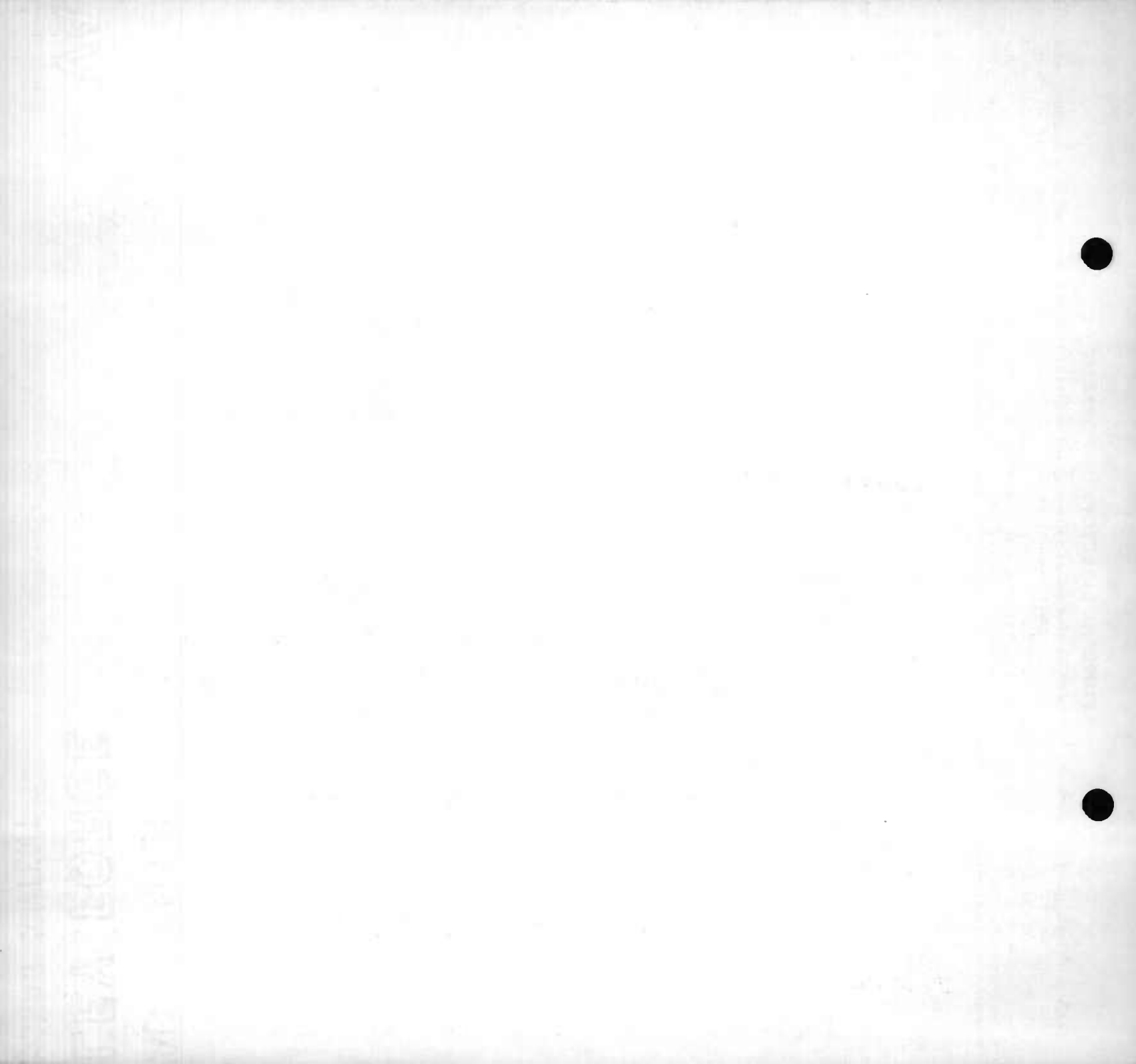
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06963		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06963	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SARAH GRAY		2. DATE AND HOUR OF DEATH 7-8-66 5 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MD.		A. STATE MD B. COUNTY 15-38			
5. SEX Female		6. RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH 1902		9. AGE (In years lost birthday) 64		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Chart	
18. 332X41260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Cerebral Thrombosis DUE TO (B) Gen. Arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3-4 days Chronic	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus		Years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-6-1966 to 7-8-1966, that (I) (we) last saw the deceased alive on 7-7-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Renato R. Espina		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-8-66	
23C. PHYSICIAN'S NAME (Type) RENATO R. ESPINA		23D. ADDRESS LUTHERAN HOSP. OF MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 11, 66		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION Baltimore MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles R. Law			
25D. ADDRESS 802 Madison Ave.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06964	
BIRTH NO. 66 06964				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mahamed Safy			2. DATE AND HOUR OF DEATH 7-8-66 9 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1617 N. Payson Street		
5. SEX m	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 6-14-92	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LADDER		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT	11. BIRTHPLACE (State or foreign country) INDIA Calcutta		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNK.			14. MOTHER'S MAIDEN NAME UNK.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-01-7665	17. INFORMANT Elizabeth Safy ADDRESS 1617 N Payson ST.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic bronchitis and emphysema years			CAUSE OF DEATH (A) irreversible shock DUE TO 2 hr. (B) Anteroseptal Myocardial Infarction DUE TO 2 days (C) Arteriosclerotic cardiovascular disease DUE TO years		
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NONE		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> None		21F. HOW DID INJURY OCCUR? None	
22. I certify that (1) (this hospital) attended the deceased from 7/5 19 66 to 7/8 19 66 , that (1) (we) last saw the deceased alive on 7/8 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip B. Dvoskin				23B. DATE SIGNED 7/8/66	
23C. PHYSICIAN'S NAME (Type) Philip B. Dvoskin				23D. ADDRESS 8014c Woodgate Ct. Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-12-66		24C. NAME of CEMETERY or CREMATORY Arbutus	
24D. LOCATION (City, town, or county) (State) Arbutus Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR MORTON J. DYETT ADDRESS 1701 LAURENS			



1
D-540

66 06985

BALTIMORE CITY HEALTH DEPARTMENT

66 06985

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Thelma Donnell

2. DATE AND HOUR PRONOUNCED DEAD

7/5/66 5:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

721 Reservoir St.

5. SEX

female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 2, 1930

9. AGE (in years
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Nance

14. MOTHER'S MAIDEN NAME

Hattie Roman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Leon Dickerson, 2513 Quantico Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Spontaneous intra-cerebellar hemorrhage
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/5/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-8-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 11 1966

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Charles R. Law

ADDRESS

802 Madison Ave.

WALLEN FORCE

WALLACE COUNTY

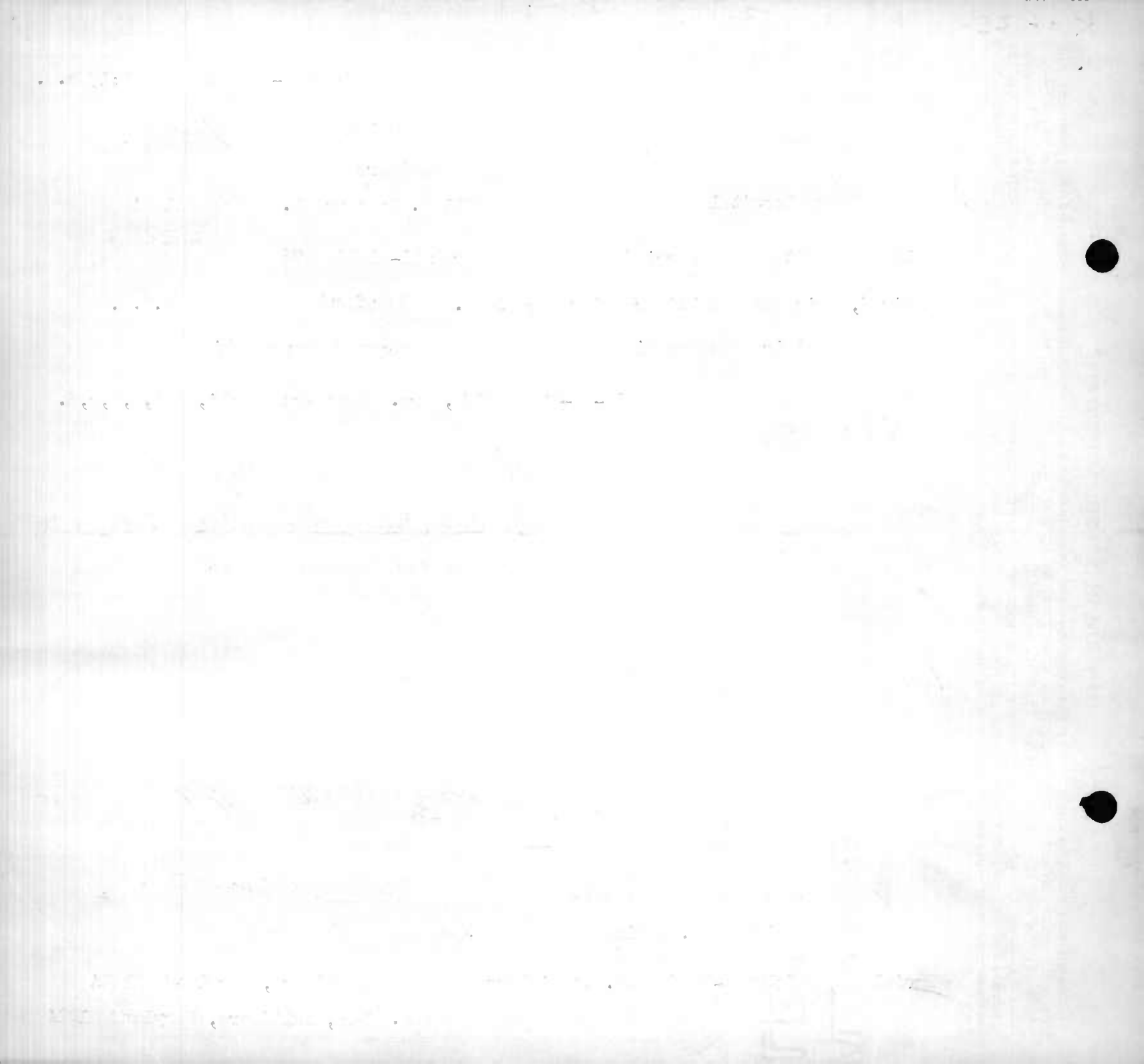
1911

WALLACE COUNTY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 06966					66 06966				
BIRTH NO.					Registered No.				
1. NAME OF DECEASED JAMES KRUSZYNSKI					2. DATE AND HOUR OF DEATH July 9 - 1966 7:15 a.m. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1011 S. Potomac St. 21224				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 31 - 1890	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Fireman			10B. KIND OF BUSINESS OR INDUSTRY Baltimore City Fire Dept.			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Casimir Kruszynski					14. MOTHER'S MAIDEN NAME Maryanna Kruszynski				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-36-1728		17. INFORMANT Wife, Mrs. Helen Kruszynski, # 4,a,b,c,d.				ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 561.01 (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) Acute Myocardial Infarction < 5 min				
					(B) Previous Myocardial Infarction 9 days				
					(C) Incarcerated Inguinal Hernia —				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION June 30, 1966			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Incarcerated Inguinal Hernia			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 6-27 19 66 to 7/9 19 66 , that (I) (we) last saw the deceased alive on 7/9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Michael A. Ellis M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> Intern			23B. DATE SIGNED 7/9/66	
23C. PHYSICIAN'S NAME (Type) Michael A. Ellis M.D.					23D. ADDRESS Mercy Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE July 12-1966		24C. NAME of CEMETERY or CREMATORY St. Stanislaus			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224	
25A. DATE REC'D BY HEALTH DEPT. Jul 11 1966			25B. NAME OF REGISTRAR Robert E. Farber			25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA, Baltimore, Maryland 21224			



CERTIFICATE OF DEATH

Registered No. 66 06967

BIRTH NO.

66 06967

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

William Day

2. DATE AND HOUR OF DEATH

July 3, 1966 11:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Provident Hospital
1514 Division Street
Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2528 Madison Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

3-25-1895

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Day Sr.

14. MOTHER'S MAIDEN NAME

Amadella Burke -

15. Was Deceased Ever in U. S. Armed Forces?

(Yes/no or unknown) (If yes, give war or date of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Bertrude Day - 2528 Madison Ave

18. 331X4003.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) CVA
DUE TO

ANTECEDENT CAUSES

(B) ASVD
DUE TODISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(C) Unilateral pleural effusion
Tbc ?II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 26, 1966 to July 3, 1966,
that (I) (we) lost saw the deceased alive on July 3, 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Amini

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

July 3, 1966

23C. PHYSICIAN'S
NAME (Type)

Dr. Amini

23D. ADDRESS

M.D.

1514 Division Street

24A. BURIAL CREMATION
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial July 6 1966

Mt Auburn Cent.

Mt. Wernia Cent.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 11 1966

Robert E. Farley

Garrie V. Cooper - 512 N. Carrollton Ave

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

P-626

66 06968

BALTIMORE CITY HEALTH DEPARTMENT

66 06968

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

WILLIAM PARKER

2. DATE AND HOUR PRONOUNCED DEAD

July 3, 1966 10:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bon Secour Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

20 N. Wheeler Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday)

16

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Aspiration of gastric contents
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Acute alcoholism
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Unknown

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

July 3, 1966

?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

X

21F. HOW DID INJURY OCCUR?

Excessive amount of alcohol

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 4, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

7-7-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION (City, town, or county)

Westport, Ind

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 11 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Carrie V. Cooper
Joseph R. Rife

ADDRESS

512 N. Carrollton St
2212 N. Northway

WALLACE BOFFLE

66 06969

BALTIMORE CITY HEALTH DEPARTMENT

66 06969

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES E. HAWTHORNE SR.

2. DATE AND HOUR PRONOUNCED DEAD

7-6-66

9:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1037 Maiden Choice Lane 4613 WILKENS AVE.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

NOV. 28, 1906

9. AGE (In years
last birthday)

59

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CUSTODIAN

10B. KIND OF BUSINESS OR INDUSTRY

MOTEL

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HARRY F. HAWTHORNE

14. MOTHER'S MAIDEN NAME

GERTRUDE F. WILKENS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

214-09-6752

17. INFORMANT

WILLIAM D. HAWTHORNE 1048 CORBETT ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUDIGER BREITENECKER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-6-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7/9/1966

23C. NAME of CEMETERY or CREMATORY

CEDAR LAWN CEMETERY

23D. LOCATION

(City, town, or county)

(State)

WASHINGTON CO., MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

JUL 11 1966

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

CHARLES M. ROUZER HAGERSTOWN, MARYLAND

1
W-656

66 06970

BALTIMORE CITY HEALTH DEPARTMENT

66 06970

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN David WARNER

2. DATE AND HOUR PRONOUNCED DEAD

July 4, 1966

9:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

509 W. Mulberry Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

509 W. Mulberry Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

January 1921

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Dish washer

10B. KIND OF BUSINESS OR INDUSTRY

Hotel

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John L. Warner

14. MOTHER'S MAIDEN NAME

Catherine Tyler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 2

16. SOCIAL
SECURITY NO.

218-05-4067

17. INFORMANT

ADDRESS

Mrs. Evelyn Warner 3342 E. Baltimore St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

Fatty infiltration of the liver

(A).....
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 4, 1966

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/11/1966

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 11 1966

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

ADDRESS

John A. Moran Inc. 3000 E. Baltimore St.

WANTING PEOPLE

1
F-236

66 06971

BALTIMORE CITY HEALTH DEPARTMENT

66 06971

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <i>Edward Fewster</i>		2. DATE AND HOUR PRONOUNCED DEAD <i>July 9 66</i> <i>10 45 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>X</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1431 Curie Way, Balto. Ambulance #2</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>26-36</i>	
D. STREET ADDRESS (If rural, give location) <i>1431 Curie way</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>June 17/1903</i>
9. AGE (In years, lost birthday) <i>63</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Christian Fewster</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give year or dates of service) <i>World War #1</i>		16. SOCIAL SECURITY NO. <i>218-07-5362</i>	
17. INFORMANT <i>Mrs Margaret Fewster</i>		ADDRESS <i>1431 Curie Way</i>	
18. <i>422.1</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>arteriosclerotic cardio-vascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Werner U. Spitz</i> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>7.10.66</i>	
23A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23B. DATE <i>7/13/66</i>	
23C. NAME OF CEMETERY or CREMATORY <i>Balto. National</i>		23D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
24A. DATE REC'D BY HEALTH DEPT. <i>JUL 11 1966</i>		24B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>	
24C. FUNERAL DIRECTOR <i>Philip Herwig</i>		ADDRESS <i>2024 Orleans St.</i>	

WALLLEY FORGE

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WALLLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06972	
BIRTH NO. 66 06972		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Floyd Byers		2. DATE AND HOUR OF DEATH July 7, 1966 11:10 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY Baltimore			
40 St. Agnes Hospital Baltimore, Md. 21229		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 20-08			
		D. STREET ADDRESS (If rural, give location) 465 S. Augusta Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 25, 1900	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Truck Driver		11. BIRTHPLACE (State or foreign country) Carrall Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jesse E. Byers		14. MOTHER'S MAIDEN NAME Elsie L. KYARS Butler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-09-8761		17. INFORMANT ADDRESS Mrs. Beulah P. Byers Same As Above	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Ventricular tachycardia (B) DUE TO Arteriosclerotic disease (C) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 3 1966 to 7/7 1966 that (I) (we) last saw the deceased alive on 7/7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George Vash		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/8/66	
23C. PHYSICIAN'S NAME (Type) VASH		23D. ADDRESS 206, S. Gilmer, Balt. 23			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 10, 1966		24C. NAME OF CEMETERY or CREMATORY Pine Grove Cemetery	
		24D. LOCATION (City, town, or county) (State) Mt. Airy, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR ADDRESS C. M. Waltz Box 241 Sykesville, Md.	

Anterior lateral
Anterior lateral
Anterior lateral
Anterior lateral
Anterior lateral

1/11 0 1/11 3 1/11 3 1/11 3

1/11 3 1/11 3 1/11 3 1/11 3 1/11 3

1/11 3 1/11 3 1/11 3 1/11 3 1/11 3

APPROVAL BY MED. EXAM.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06973		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06973	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Walter WEBB		2. DATE AND HOUR OF DEATH 7/5/66	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		M. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hosp.		A. STATE M.D.		B. COUNTY 1605	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto			
		D. STREET ADDRESS (If rural, give location) 2506 CALVERTON HSTS. AVE			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/8/87	9. AGE (In years lost birthday) 79	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10B. KIND OF BUSINESS OR INDUSTRY christ church		11. BIRTHPLACE (State or foreign country) M.D.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Weht		14. MOTHER'S MAIDEN NAME Cliza Ronig	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 16-031630A		17. INFORMANT Lucy Webb	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Hypertensive Cardio-vascular Heart Disease (essential and hypertensive)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/25/1966 to 4/25/1966, that (I) (we) last saw the deceased alive on 4/25/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Adam N. Coker		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/8/66	
23C. PHYSICIAN'S NAME (Type) ODOM N. COKER		M.D.		23D. ADDRESS 3701 Liberty Hts. ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/66		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) Anne Arundel Co.		(State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 14 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph J. Lohr Jr.	
				ADDRESS 1301 N. Central Ave.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 86 06974		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 86 06974	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print)		BUXENSTEIN RAYMOND F		2. DATE AND HOUR OF DEATH JULY 7 1966 12:15P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD 21227 B. COUNTY Balt		5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL		C. STREET ADDRESS (If rural, give location) 4424 ANNAPOLIS ROAD		D. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-23-09	9. AGE (In years lost birthday) 57	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE FITTER		10B. KIND OF BUSINESS OR INDUSTRY Central Heating		11. BIRTHPLACE (State or foreign country) BALTIMORE MD	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JOHN BUXENSTEIN		14. MOTHER'S MAIDEN NAME FANNIE BAKER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07 1855		17. INFORMANT ST AGNES HOSPITAL CATON & WILKENS AV	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 433.014-202.1 Cardiac arrest		CAUSE OF DEATH Arterio Sclerosis Lymphoma, Lymphatic - @ 2 mo e severe anemias		INTERVAL BETWEEN ONSET AND DEATH 5 min 5-10 yrs	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 2 19 66 to JULY 7 19 66, that (I) (we) last saw the deceased alive on JULY 7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip Whelan		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-7-66	
23C. PHYSICIAN'S NAME (Type) PHILIP WHELAN		23D. ADDRESS CATON & WILKENS AVE. BALTIMORE MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/66		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem.	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. JUL 11 1966		24F. NAME OF REGISTRAR Robert E. Farley	
24G. ADDRESS Schimunek Funeral Home, Inc. 2601 E. Madison St.		24H. ADDRESS 2601 E. Madison St.			

ST AGNES HOSPITAL

RECEIVED

DATE

TIME

ATTENDING MD

BARBARA BAKER

RECEIVED BY

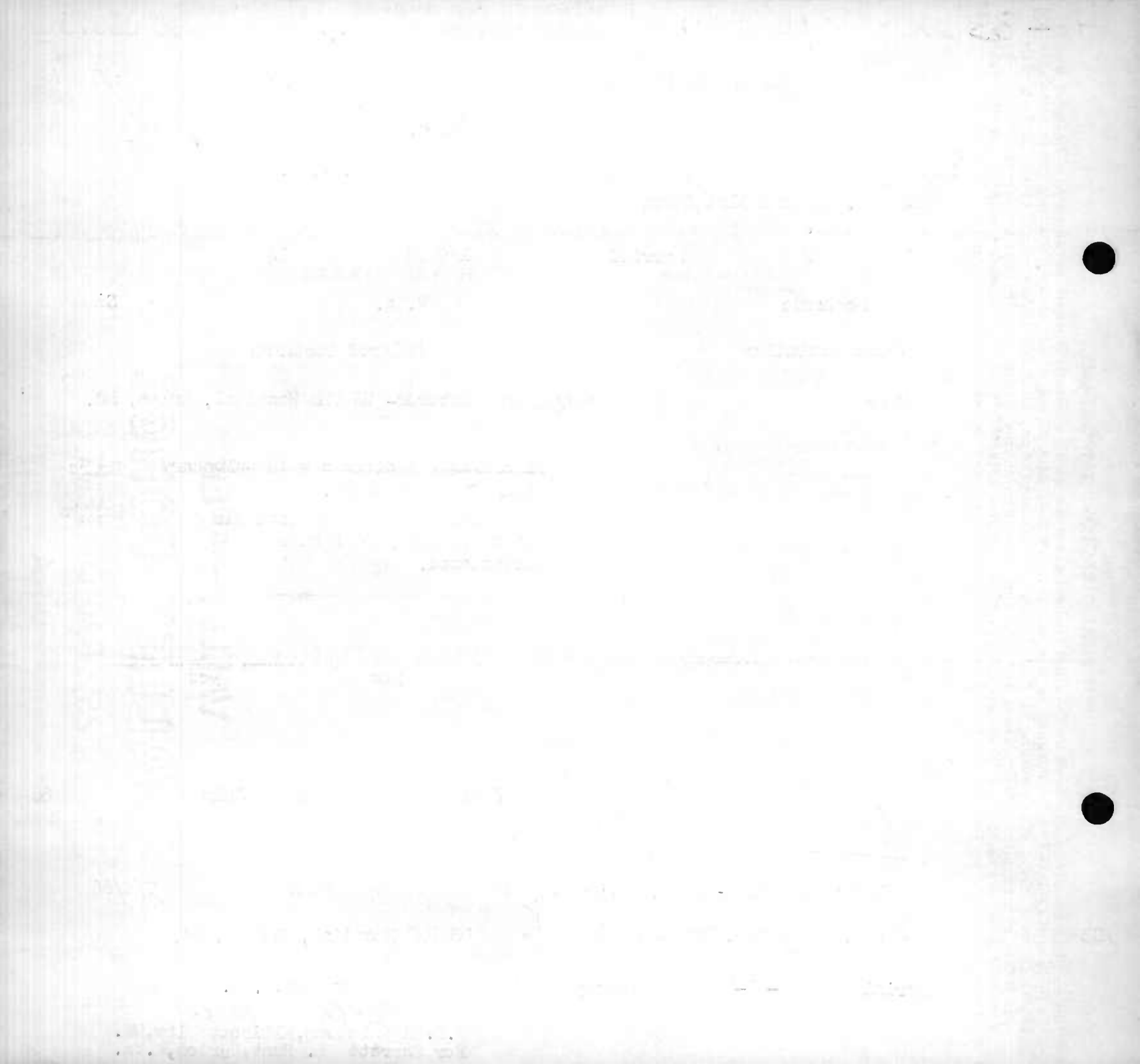
20 JUL 1968

ST. AGNES HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

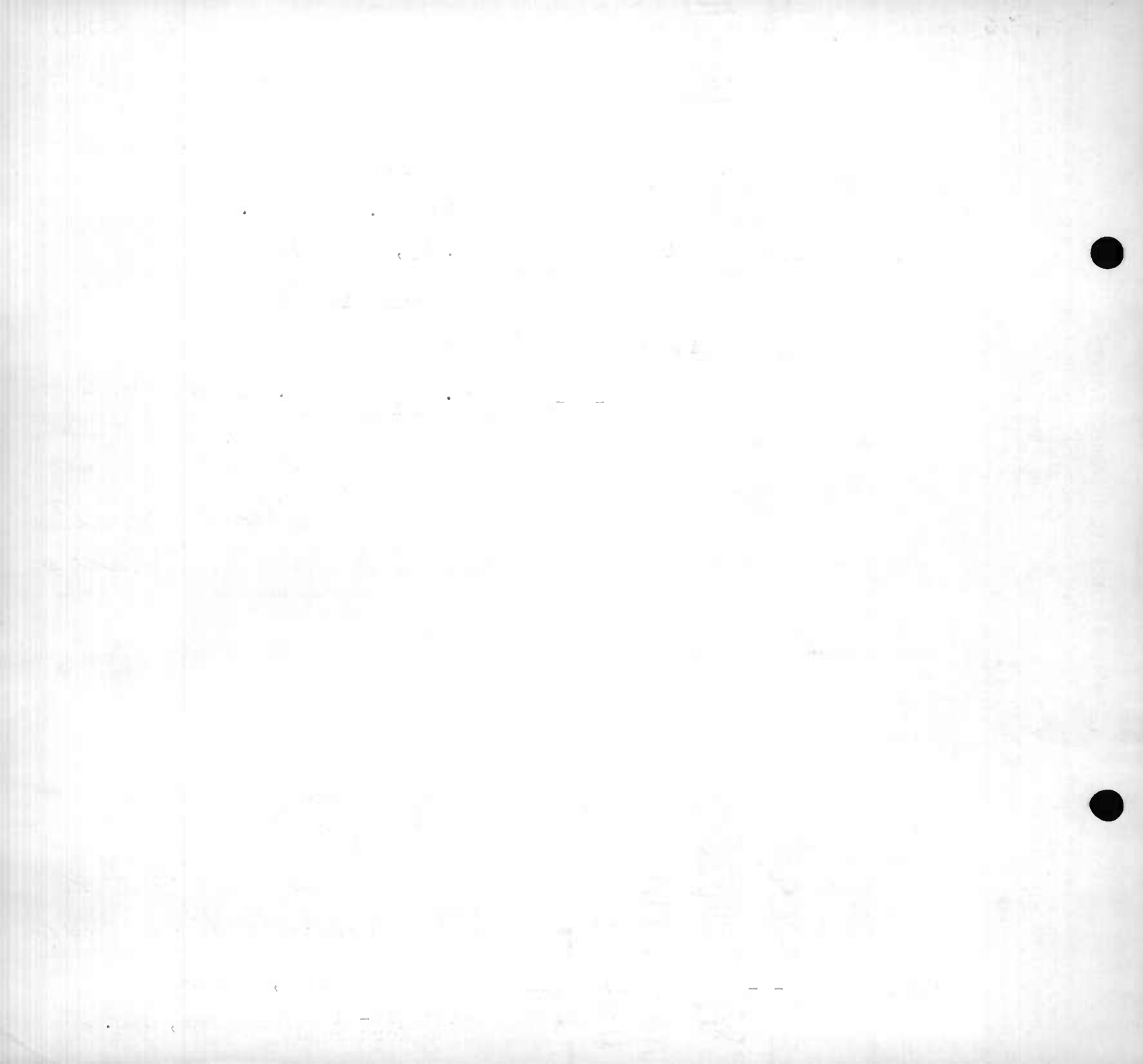
BALTIMORE CITY HEALTH DEPARTMENT										
66 06975					CERTIFICATE OF DEATH		Registered No. 66 06975			
BIRTH NO.					2. DATE AND HOUR OF DEATH					
M.E. CASE NO.					July 8, 1966 9:30 A.M.					
1. NAME OF DECEASED (Type or Print)					3. PLACE OF DEATH IN BALTIMORE, MARYLAND					
BILLIE LEE HOSTUTLER					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street					A. STATE W.Va.					
					B. COUNTY V-45					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glover Gap, W.Va.					D. STREET ADDRESS (If rural, give location)					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 1/9/32	9. AGE (In years last birthday) 34	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME James Hostutler					14. MOTHER'S MAIDEN NAME Mildred Toothman					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None			16. SOCIAL SECURITY NO. 234=44=1600		17. INFORMANT Records- US PHS Hospital, Balto, Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					CAUSE OF DEATH (A) Hemorrhagic diathesis with pulmonary hemorrhage and edema. (B) Embryonal carcinoma of testicle With pulmonary & hepatic metastases. (C)					
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from June 12 1966 to July 8 1966, that (I) (we) lost saw the deceased alive on July 8 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Jon M. Beauchamp, Surgeon (R)								23B. DATE SIGNED 7/8/66		
23C. PHYSICIAN'S NAME (Type) Jon M. Beauchamp, Surgeon (R)					23D. ADDRESS US PHS Hospital, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7-11-1966		24C. NAME of CEMETERY or CREMATORY Harmony		24D. LOCATION (City, town, or county) (State) Burton, W.Va.			
25A. DATE RECEIVED BY HEALTH DEPT. JUL 11 1966			25B. NAME OF REGISTRAR Robert E. Farley			25C. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md. For Garrett L. Hunt, Burton, W.Va.			ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

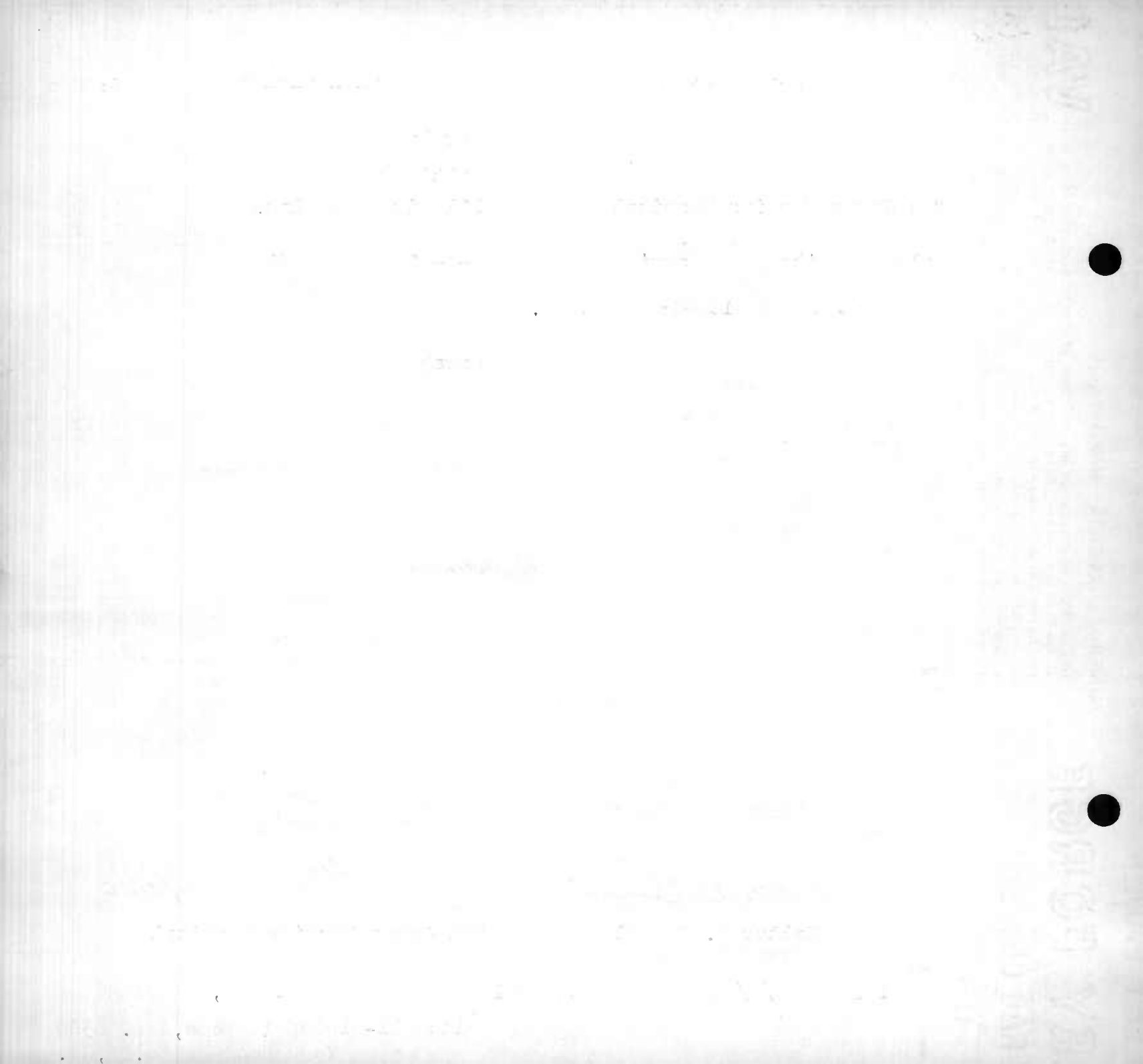
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06976		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06976	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Margaret Hollyday		2. DATE AND HOUR OF DEATH 7-6-66 2 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Bolton Hill N H		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1025 E. Lake Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 15, 1885	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Joseph Milton Ritchie		14. MOTHER'S MAIDEN NAME Mary Magee			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-16-5460		17. INFORMANT Mrs. Elizabeth H. Clawson Shiel Road	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Septicemia		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Decubitus ulcers ASCVD		INTERVAL BETWEEN ONSET AND DEATH Hours Months Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-11-1966 to 7-6-1966, that (I) (we) last saw the deceased alive on 7-5-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard K Gundry		23B. DATE SIGNED 7-6-66			
23C. PHYSICIAN'S NAME (Type) Richard K Gundry M.D.		23D. ADDRESS 2 W. University Pkwy 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-66		24C. NAME OF CEMETERY or CREMATORY Spring Hill	
24D. LOCATION Easton, Maryland					
25A. DATE RECEIVED BY HEALTH DEPARTMENT JUL 11 1966		25B. NAME OF REGISTRAR Robert E. Fisher, MA		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Road	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
M.E. CASE NO.				66 06977				66 06977			
1. NAME OF DECEASED (Type or Print)				Charles Bathon				2. DATE AND HOUR OF DEATH XXXX 7-5-66 6:00 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland				Baltimore			
The Johns Hopkins Hospital				D. STREET ADDRESS (If rural, give location)				321 Birkwood Place			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Male	White	Married	8-5-02	63	Guard at the Equitable Trust Co.			USA		Sarah	
16. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Dissecting Aortic Aneurysm Hypertension							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CORONARY ARTERY DISEASE							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
3 7/3/66				Dissecting Aortic Aneurysm				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 7/3/66 to 7/5 1966 that (we) last saw the deceased alive on 6:00 7/5/66 19 66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Walter D. Gundel				7/5/66							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
Walter D. Gundel				The Johns Hopkins Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
Burial				6/8/66				New Cathedral			
24D. LOCATION (City, town, or county)				24E. DATE REC'D BY HEALTH DEPT.				24F. NAME OF REGISTRAR			
Baltimore, Maryland				JUL 11 1966				Robert E. Farber			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
								Mitchell-Wiedefeld Home, Inc. 6500 York Road Balto. 12, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

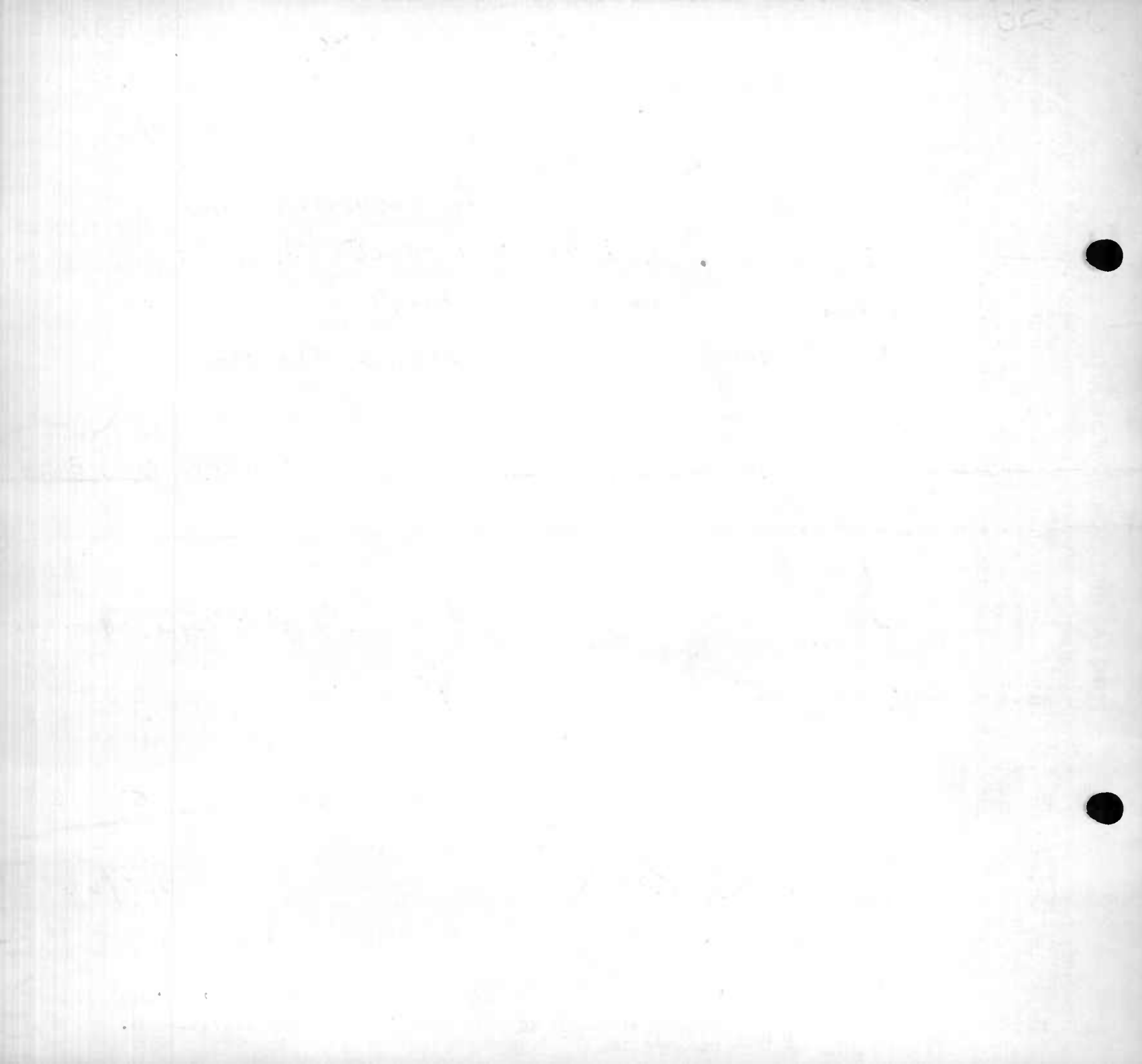
47-06-18 ED		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06978	
BIRTH NO. 66 06978		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED Frank, Florence		2. DATE AND HOUR OF DEATH 7/7/66 4:50 P.M.	
(Type or Print) Frank, Florence M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS		A. STATE MARYLAND		B. COUNTY Balti	
(If not in hospital or institution, give street address or location) 4940 EASTERN AVENUE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
BALTIMORE, MARYLAND 21224		D. STREET ADDRESS (If rural, give location) 1618 RICKENBACKER ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-14-06	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DANIEL F. McCloud			14. MOTHER'S MAIDEN NAME SARAH Bickhart		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 172-05-1919	17. INFORMANT RECORDS: BALTIMORE CITY HOSPITALS		
18. 260X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO Myocardial infarction		12 days	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO Generalized arteriosclerosis cardiovascular disease			
ANTECEDENT CAUSES		(C) Diabetes mellitus			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 25 19 66 to July 7 19 66 , that (I) (we) lost saw the deceased alive on July 7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carl Winterstein				23B. DATE SIGNED 7/7/66	
23C. PHYSICIAN'S NAME (Type) Carl Winterstein				23D. ADDRESS 4940 EASTERN AVE BALTIMORE, MD. 21224	
				M.D. Baltimore City Hospitals; Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-11-1966		24C. NAME of CEMETERY or CREMATORY Cedar Lawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Lancaster Pa.	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR C. F. Evans & Son 8802 Harford Rd.	
				ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
MONTGOMERY CO. MD. 66 U6979					Registered No. 66 U6979				
BIRTH NO. 66 U6979					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) LOTTIE LEE JONES					2. DATE AND HOUR OF DEATH July 6, 1966 8²⁰ P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL					A. STATE MARYLAND				
(If not in hospital or institution, give street address or location)					B. COUNTY				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)				
BOWIE					8031 CHESTNUT AVE.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Single (never married)	8. DATE OF BIRTH 1-15-66	9. AGE (In years last birthday) 1/2 yr	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME Robert Jones			14. MOTHER'S MAIDEN NAME Patricia Martin						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. 754,51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGENITAL HEART DISEASE FROM BIRTH			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO			(B) DUE TO			
(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Multiple Congenital Anomalies, including cleft lip + palate, microphthalmia, abnormal									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from March 25, 1966 to July 5, 1966 , that (I) (we) last saw the deceased alive on July 5, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Richard D. Bland M.D.						23B. DATE SIGNED 7/5/66			
23C. PHYSICIAN'S NAME (Type) RICHARD D. BLAND M.D.						23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 9, 1966		24C. NAME OF CEMETERY or CREMATORY Ft Lincoln Cemetery		24D. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farley, MA		25C. FUNERAL DIRECTOR F Gasch's Sons		ADDRESS Hyattsville Md.			

JUL 11 1966



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 06980		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06980	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Winklen Ambrose A.		11:10 AM 7/7/66 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
Univ. Hosp		Md.		21-02	
If not in hospital or institution, give street address or location		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore		21230	
		D. STREET ADDRESS (If rural, give location)			
		1209 W. Ostend St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	White	Married	11/4/1904	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Cook		RESTAURANT TAVERN		Missouri, Louis	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
— (Don't know) ?		— (Don't know) ?		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		492-103401		Wife - Adn Winklen (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Pulmonary Edema 8 hrs.	
ANTECEDENT CAUSES		(B) DUE TO		CHF	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		5 PM 7/7		19 66 11:10 AM 7/7/66	
that (I) (we) last saw the deceased alive on		7/7		19 66 and that in (my) (our) opinion death occurred on the date	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
P.P. Toskes				7/8/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
P.P. Toskes		Univ. Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		JUL 9-66		ST. PAUL'S CEMETERY	
				24D. LOCATION (City, town, or county) (State)	
				CARDIFF AVE. BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 11 1966		P. B. E. F. Evans		CURTIS E. EVANS 1400 S. CHARLES ST. 21230	

CHRIS E. EVANS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. _____	
BIRTH NO. 66 06981		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>George G. Butz</u>		2. DATE AND HOUR OF DEATH <u>7-9-66</u> <u>2:30 p.m.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Balto. Gen. Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>411 E. Gittings St.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>July 15, 1916</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>George T. Butz</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Wolf</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes # 2</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Margaret Wenger 411 E. Gittings St</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>acute infectious obstruction one week</u>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ulcerations and stricture of the small bowel</u>		(B) DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-9-66</u> to <u>7-9-66</u> that (I) (we) last saw the deceased alive on <u>7-9-66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Juan C. Arrabal</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Juan C. Arrabal</u>		23D. ADDRESS M.D. <u>South Baltimore General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7 12 1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Western</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 11 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>McCully, Inc. 130 E. Fort Ave. # 30</u>	

Page 2

Northwest corner of the
small house

7-2 7-2 7-2

from 6 miles

John C. H. 1891

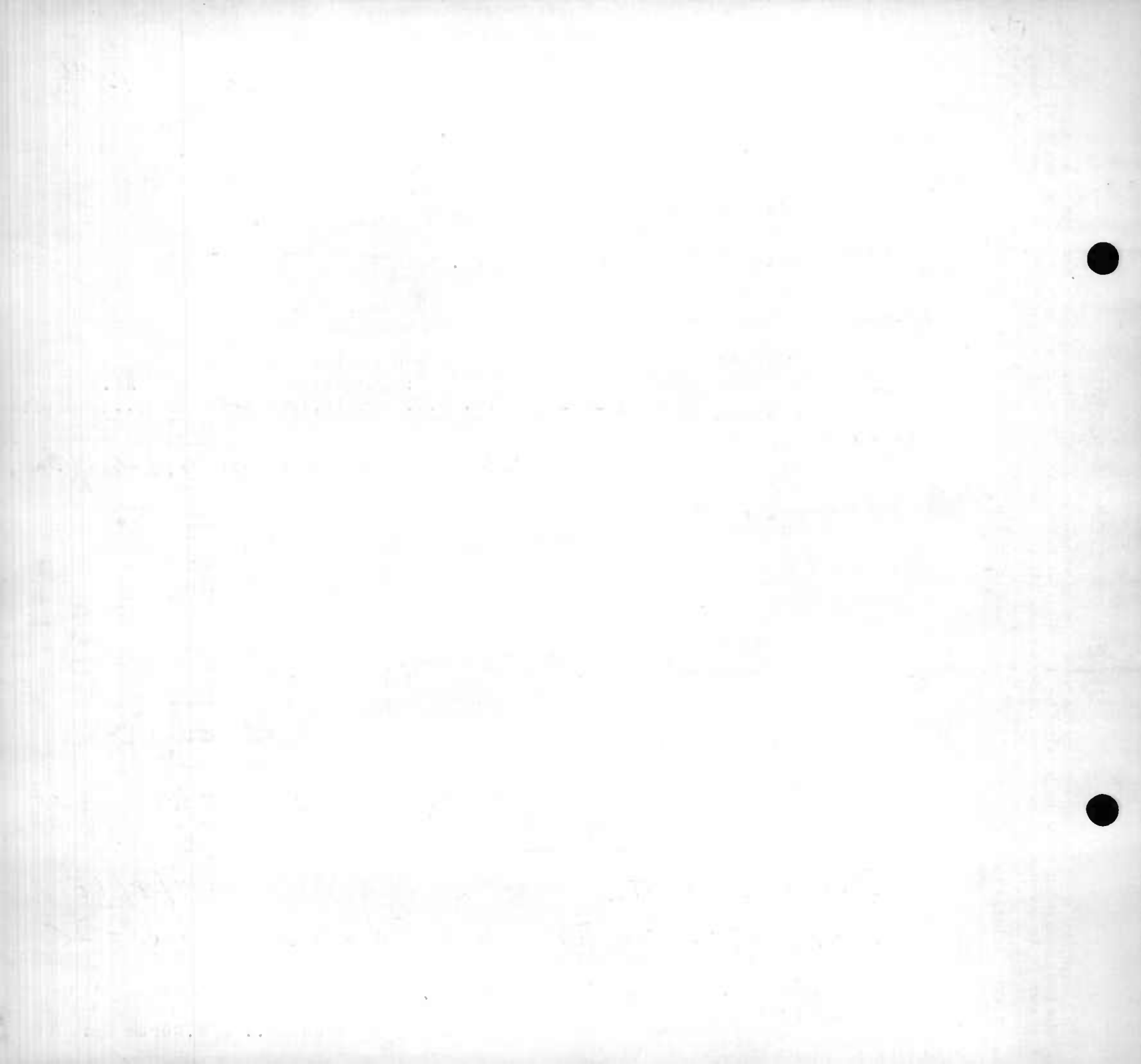
South Bellman Street

McCally and 1306 1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

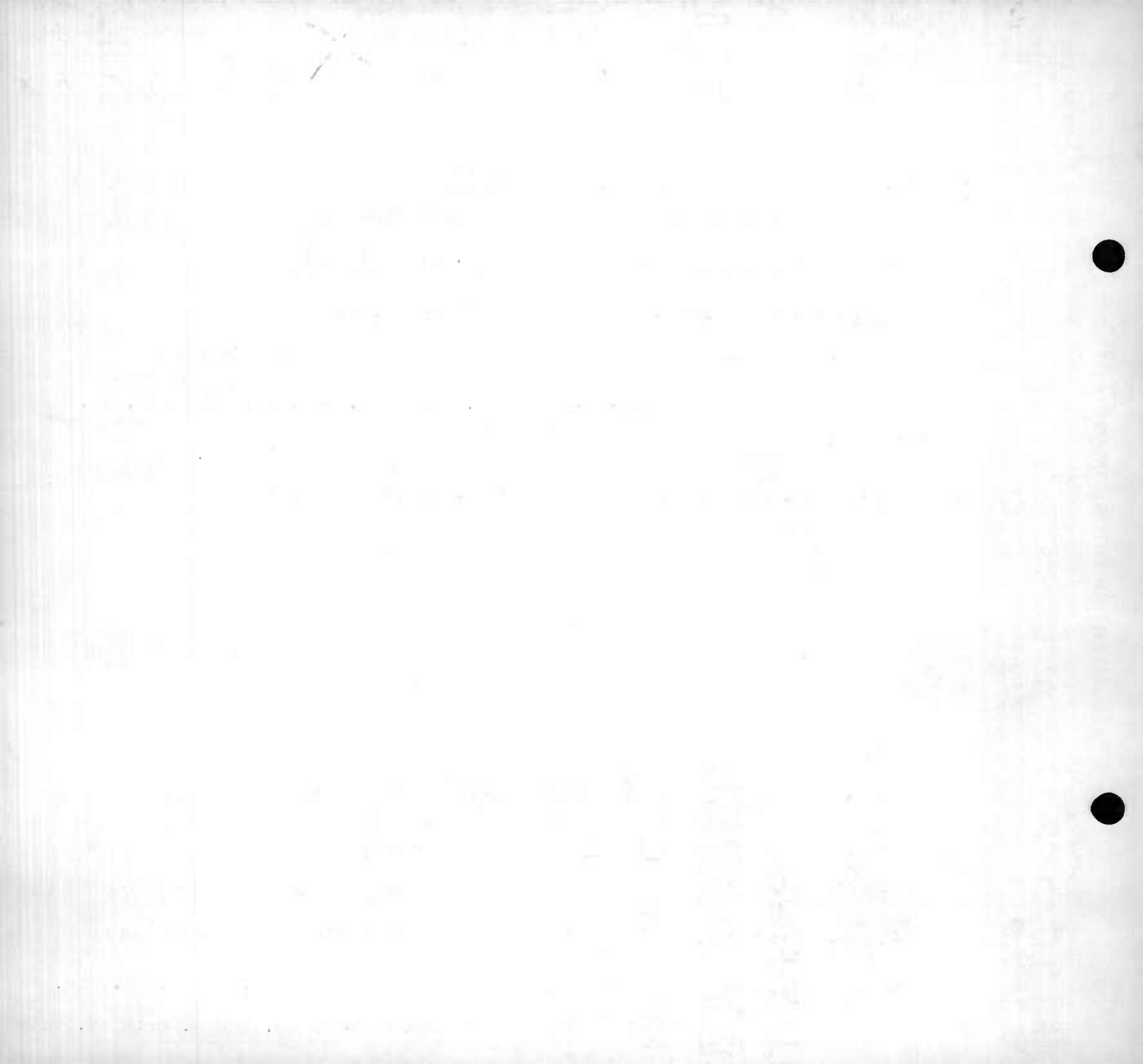
BALTIMORE CITY HEALTH DEPARTMENT																	
BIRTH NO. 66 06982					CERTIFICATE OF DEATH					Registered No. 66 06982							
M.E. CASE NO.										2. DATE AND HOUR OF DEATH							
1. NAME OF DECEASED (Type or Print) MINNIE LEAR WOLFE										7/8/66 12:40 P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION Clifton Nursing Home 3502 Clifton Avenue					A. STATE Md.					B. COUNTY							
(If not in hospital or institution, give street address or location)										C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore							
										D. STREET ADDRESS (If rural, give location) 2202 Garrison Blvd.							
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH Feb. 19, 1879		9. AGE (In years last birthday) 87		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY Boarding House				11. BIRTHPLACE (State or foreign country) Coshocton, Ohio				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Henry Lear						14. MOTHER'S MAIDEN NAME Sarah Louise Marshall											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. A 213-34-6261		17. INFORMANT: Daughter Mrs. J.R. Hoshall, 1966 Fairfax Rd., Annapolis Md.				ADDRESS							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 331X I Cerebral hemorrhage one-half hour										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION 0										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 11/30 1951 to 7/8 1966, that (I) (we) last saw the deceased alive on 6/16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
23A. SIGNATURE Robert A. Reiter M.D.										23B. DATE SIGNED 7/8/66							
23C. PHYSICIAN'S NAME (Type) Robert A. Reiter M.D.										23D. ADDRESS 606 Edmondson Ave. - 28							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/12/66		24C. NAME of CEMETERY or CREMATORY South Lawn Cemetery				24D. LOCATION (City, town, or county) (State) Coshocton OHIO							
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966				25B. NAME OF REGISTRAR Robert E. Farley, M.D.				25C. FUNERAL DIRECTOR Stewart & Mowen Co. 108 W. North Av., City				ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

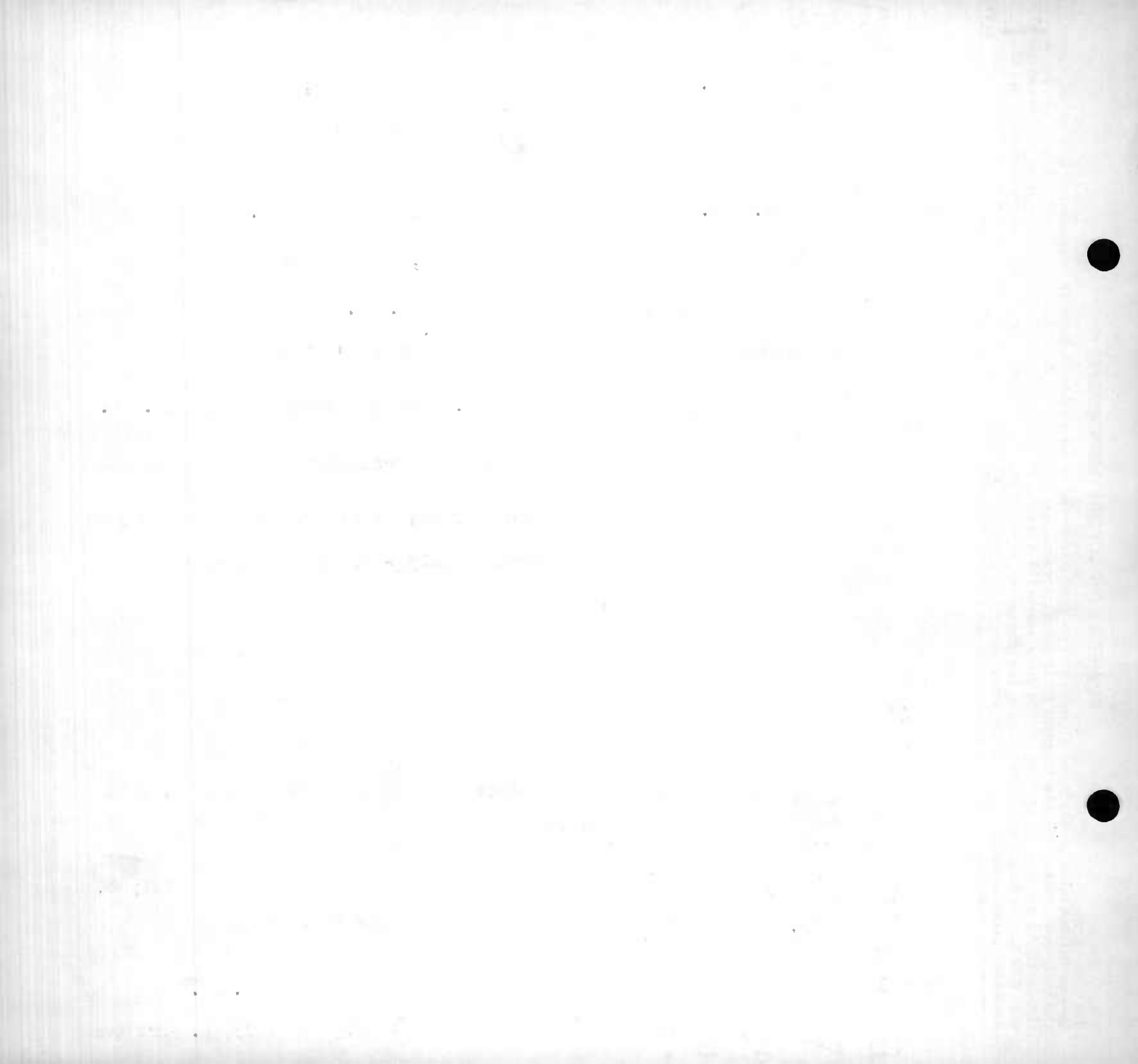
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06983	
BIRTH NO. 66 06983		CERTIFICATE OF DEATH		Registered No. 66 06983	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BENNETT, MABLE (MABLE PATE BENNETT)		2. DATE AND HOUR OF DEATH 7/10/66 9:15 A M	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Brooklandville D. STREET ADDRESS (If rural, give location) Falls Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Oct. 7, 1904	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Teacher		10B. KIND OF BUSINESS OR INDUSTRY Priv. School		11. BIRTHPLACE (State or foreign country) Pittsboro, Miss.	
13. FATHER'S NAME Ernest Pate (Pittsboro)		12. CITIZEN OF WHAT COUNTRY? Minnie Lee Countis (Pittsboro)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-38-5903		17. INFORMANT: Son 2720 Kenbury Road Mr. Gerald R. Bennett, Richmond, Va.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH METASTATIC ANAPLASTIC CARCINOMA OF LUNG		INTERVAL BETWEEN ONSET AND DEATH 16 mos.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None					
19A. DATE OF OPERATION No		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/10 1966 to 7/10 1966 , that (I) (we) last saw the deceased alive on 7/10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allen Ginsberg		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/10/66	
23C. PHYSICIAN'S NAME (Type) ALLEN GINSBERG		23D. ADDRESS 601 N. CAROLINE ST. BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE JUL 17 1966		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Cl., Md.		25A. DATE REC'D BY HEALTH DEPT. 7/10/66			
25B. NAME OF REGISTRAR Robert E. Farber, MA		25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co., 108 W. North Av., City			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

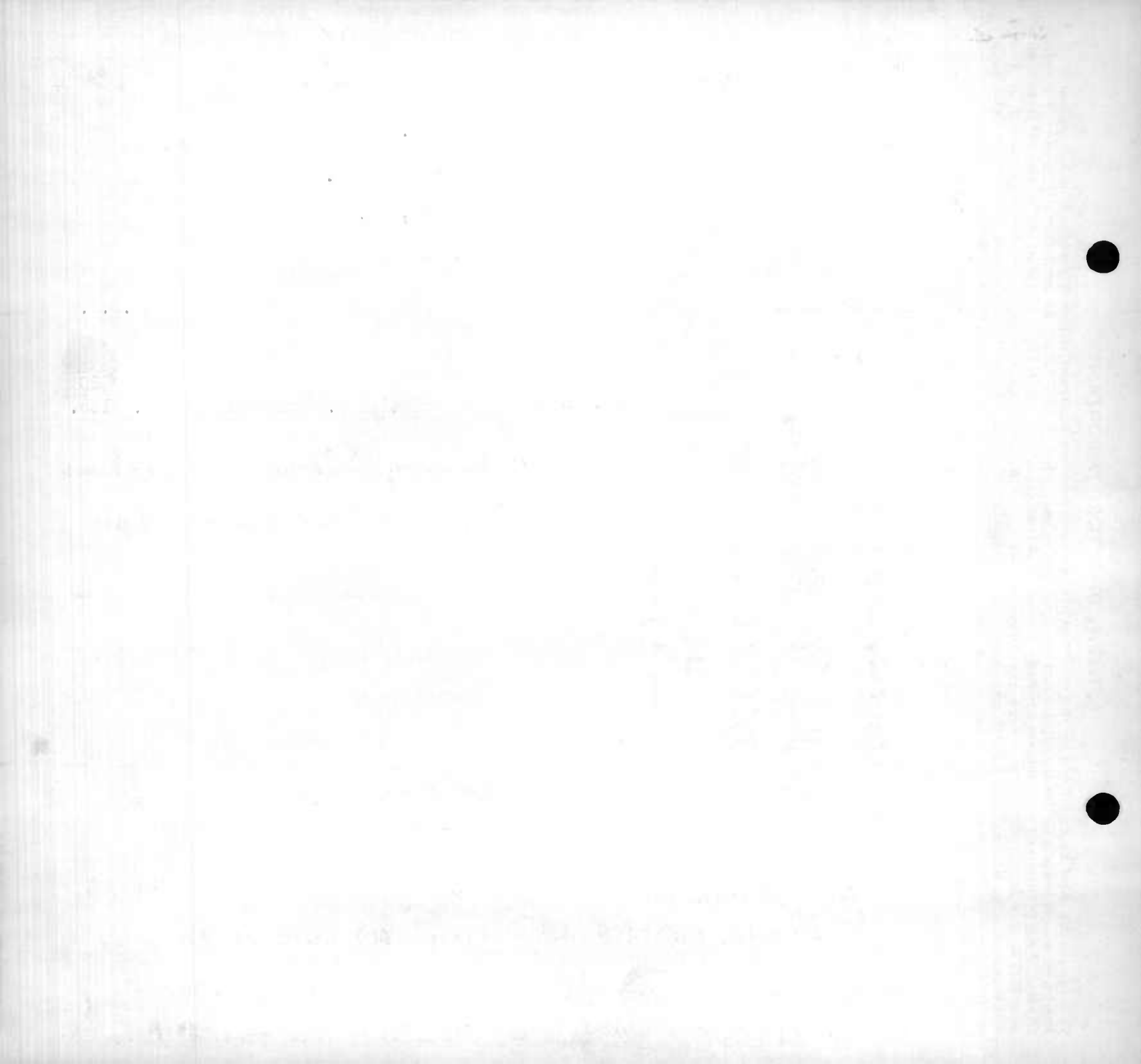
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06984</u>	
BIRTH NO. <u>66 06984</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Robert W. Bergman</u>		2. DATE AND HOUR OF DEATH <u>July 7, 1966</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>43 South Balto. Gen. Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>24-04</u> D. STREET ADDRESS (If rural, give location) <u>1600 Jackson St.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>June 27, 1904</u>	9. AGE (In years lost birthday) <u>62</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Robert Bergman</u>			
14. MOTHER'S MAIDEN NAME <u>Ellen O'Brien</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Bernard Kutchev</u> ADDRESS <u>4000 5th. St.</u>			
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Occlusion</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) <u>Cronic Cardio Vascular Disease</u> <u>2 years</u> DUE TO (C) <u>Cardiomegaly - Cronic Emphysema</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 26</u> 19 <u>64</u> to <u>July 7, 1966</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>March 25</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harry Deibel</u> M.D.		23B. DATE SIGNED <u>July 8, 1966</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Harry Deibel</u> M.D.	
23D. ADDRESS <u>1226 S Hanover Street</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>7 9 1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 11 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, MA</u>		25C. FUNERAL DIRECTOR <u>Mc Cully</u> ADDRESS <u>130 E. Fort Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 06985					66 06985				
BIRTH NO.					Registered No.				
M.E. CASE NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) Walter Potschka					2. DATE AND HOUR OF DEATH 7-8-1966 6:45 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 90 House In The Pines elair Road					A. STATE Md. B. COUNTY Balto				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Md.					D. STREET ADDRESS (If rural, give location) Chase, Md.				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 10-10-1881	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rents Boats		10B. KIND OF BUSINESS OR INDUSTRY Dundee		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-40-1618		17. INFORMANT Mr Christian C. Lawrence Box 24D. Balto.				
18. 420,01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Heart Disease					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO 24 hours 2 yrs.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JAN 19 57 to 7/7 19 66 , that (I) (We) last saw the deceased alive on 7/5 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Josef Cameron JOSEPH J. CAMERON					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-8-66		
23C. PHYSICIAN'S NAME (Type) JOSEPH J. CAMERON					23D. ADDRESS 1012 OLD NORTH PT. RD # 24				
24A. BURIAL CREMATION, REMOVAL (Specify) Crementation		24B. DATE 8-8-1966		24C. NAME of CEMETERY or CREMATORY Greenmount Avenue		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Lassalco Funeral Home		ADDRESS 7901 Belair Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

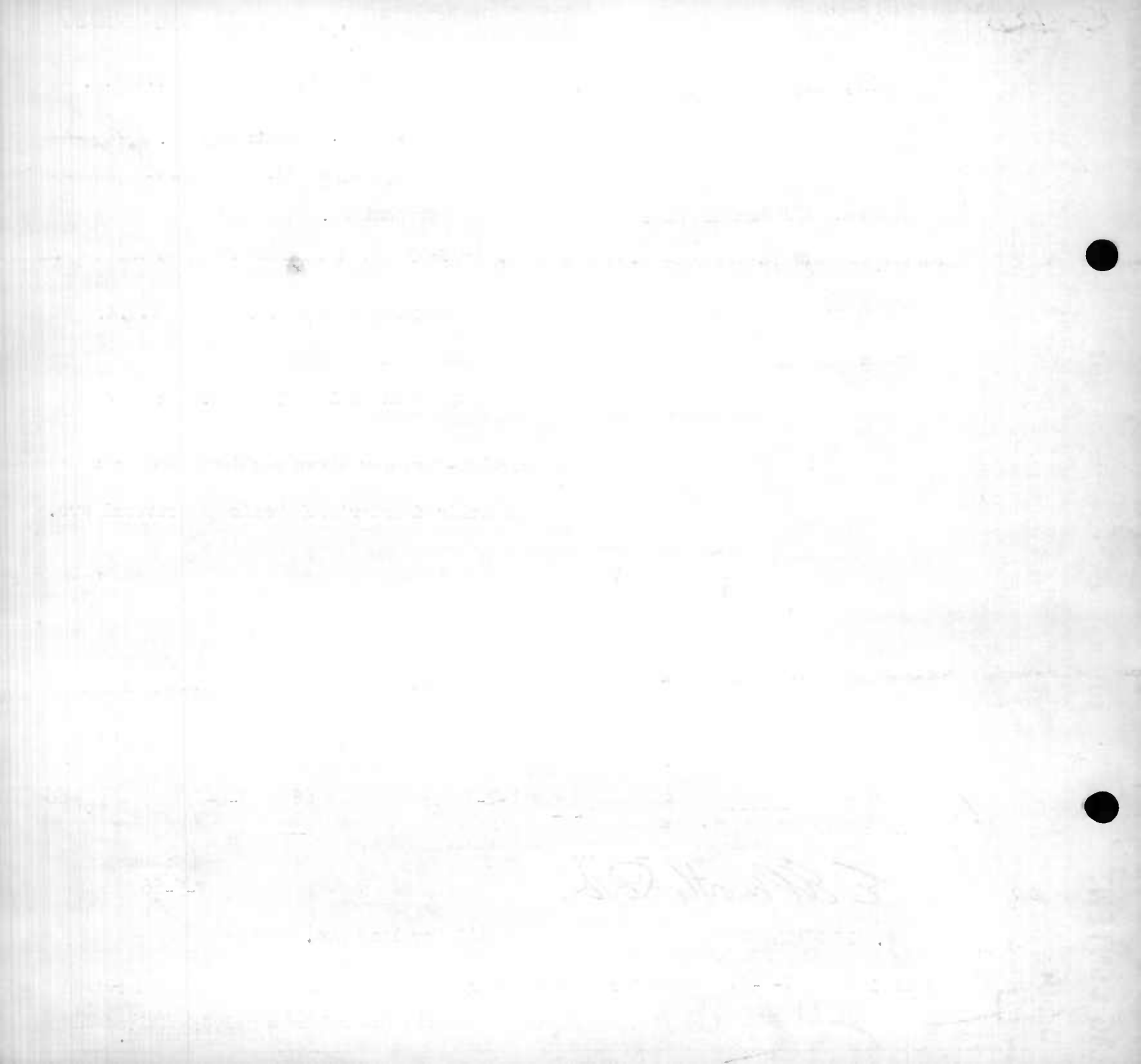
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06986		CERTIFICATE OF DEATH		Registered No. 66 06986	
1. NAME OF DECEASED (Type or Print) Alice Jones Alice Jones				2. DATE AND HOUR OF DEATH July 6, 1966 7:00 P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1102 East Eager Street Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 10-01 D. STREET ADDRESS (If rural, give location) 1102 E. Eager Street					
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6/21/1894	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10B. KIND OF BUSINESS OR INDUSTRY Boarding house		11. BIRTHPLACE (State or foreign country) Madonna, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ignatius Smith				14. MOTHER'S MAIDEN NAME Laura V. Tittle					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No ---		16. SOCIAL SECURITY NO. 217-03-5680		17. INFORMANT Marie Greene Forest Hill, Md. 21050					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA OF STOMACH, WITH DUE TO INFLAMMATION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Adenocarcinoma of stomach, with DUE TO INFLAMMATION (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 9 months			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Z		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (We) attended the deceased from June 3, 1966 to June 20, 1966 that (I) (We) last saw the deceased alive on June 20, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Edgar W. Hull</i> Edgar W. Hull				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> aa		23B. DATE SIGNED 7-7-66			
23C. PHYSICIAN'S NAME (Type) Edgar W. Hull				23D. ADDRESS Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/1966		24C. NAME OF CEMETERY or CREMATORY Mt. Joy A.M.E.		24D. LOCATION (City, town, or county) (State) Monkton, Maryland			
25A. DATE RECEIVED BY HEALTH DEPT. JUL 11 1966		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR Charles E. Kurtz		ADDRESS Jarrettsville, Md.			

Calvin's Hall

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>66 06987</u>				
BIRTH NO. <u>66 06987</u>					2. DATE AND HOUR OF DEATH <u>July 4, 1966</u> <u>7:15P.M.</u> M.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>Caulk, Mary</u>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>Boulton Hill Nursinh Home</u>					A. STATE <u>Merchant St. CampSpring, Md.</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Campspring Md.</u>				
					D. STREET ADDRESS (If rural, give location) <u>Merchant St.</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>	8. DATE OF BIRTH <u>8-13-93</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Companion</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Forsythe County N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>George Charles</u>			14. MOTHER'S MAIDEN NAME <u>Kate Crews</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mary Caulk Mohl 6101 Merchant Road</u>				
18. <u>531X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH				
					(A) <u>cerebro-vascular disea accident</u> <u>two days</u> DUE TO (B) <u>generalized arteriosclerosis</u> <u>several yrs.</u> DUE TO (C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>4-2-</u> <u>19 66</u> to <u>7-4-</u> <u>19 66</u> , that (I) (we) last saw the deceased alive on <u>7-4-</u> <u>19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>E. Ellsworth Cook</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7-5-66</u>		
23C. PHYSICIAN'S NAME (Type) <u>E. ELLSWORTH COOK</u> M.D.					23D. ADDRESS <u>2431 Maryland Ave.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-6-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>			
25A. DATE RECEIVED BY HEALTH DEPT. <u>JUL 11 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, Jr.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wilhelm Funeral Home 4308 Suitland Rd. Suitland Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06988				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06988	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GARRITY-DAISY LILLIAN				2. DATE AND HOUR OF DEATH 8:30 A.M. 7/7/66			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hosp.				A. STATE md. B. COUNTY 18-03			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 21 S. - Arlington Ave			
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 11/29/1894	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Smith				14. MOTHER'S MAIDEN NAME Daisy L. Gallier			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs Dorothy Keller		ADDRESS 18 S. - Arlington Ave	
18. 420101 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Massive pneumonia at least 10 days				CAUSE OF DEATH (A) DUE TO Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH at least 10 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/2 19 66 to 7/7 19 66 , that (I) (we) last saw the deceased alive on 7/7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Raymundo S. Magno M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/7/66	
23C. PHYSICIAN'S NAME (Type) RAYMUNDO S. MAGNO M.D.				23D. ADDRESS Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE Burial 17/6/66		24C. NAME OF CEMETERY OR CREMATORY Landon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, md.	
25A. DATE REC'D BY HEALTH DEPT. 10/6/66		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John J. Cowan & Son Inc.		ADDRESS 901 St. Hollins 23 md.	

St. Louis, Mo.
August 10, 1892
My dear Mr. Miller
I have just received
your letter of the 8th

and am glad to hear
that you are well.
I am very
kindly
yours
J. H. Miller

I have just received
your letter of the 8th
and am glad to hear
that you are well.
I am very
kindly
yours
J. H. Miller

I have just received
your letter of the 8th
and am glad to hear
that you are well.
I am very
kindly
yours
J. H. Miller

Yours very truly
J. H. Miller

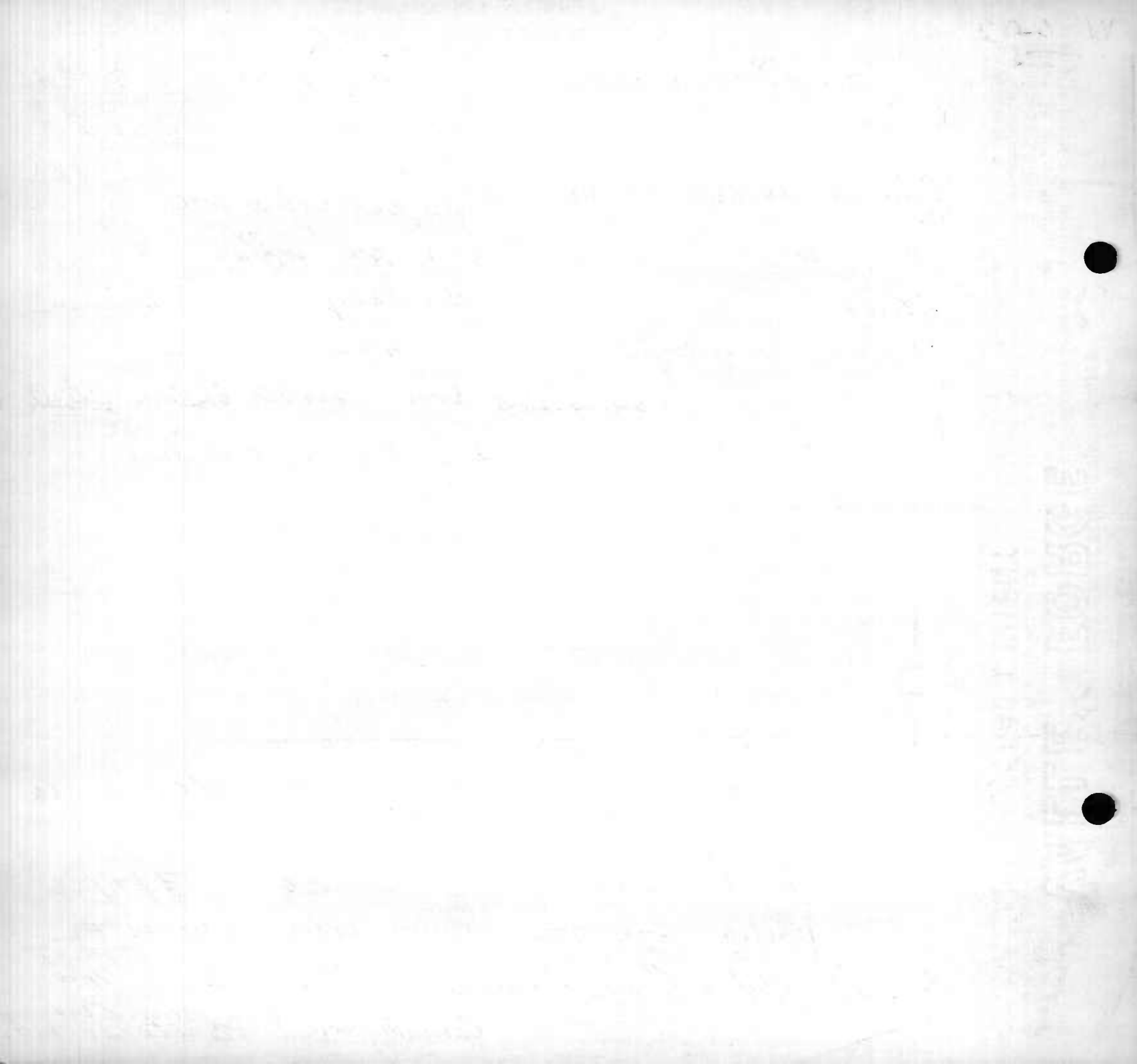
Yours very truly
J. H. Miller

W-652

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06989	
BIRTH NO. 66 06989		CERTIFICATE OF DEATH		Registered No. 66 06989	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) George J Wernsdorfer (WERNSDORFER)		2. DATE AND HOUR OF DEATH July 7, 1966 9:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hosp.		A. STATE Maryland B. COUNTY Balto			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL (and give township)) Baltimore		5300	
		D. STREET ADDRESS (If rural, give location) 152 Wiltshire Rd			
5. SEX H	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 3-7-38	9. AGE (In years lost birthday) 28 yrs.	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Martin Wernsdorfer		14. MOTHER'S MAIDEN NAME Anna		12. CITIZEN OF WHAT COUNTRY? America	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-05-4085		17. INFORMANT Son 800 Blk. Eastern Blvd.	
18. I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Congestive Heart Failure			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/30 to 7/7		19 66 to 7/7 19 66			
that (I) (we) last saw the deceased alive on 7/7 19 66		and that in (my) (our) opinion death occurred on the date			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kenneth Secary M.D.		23B. DATE SIGNED 7/7/66			
23C. PHYSICIAN'S NAME (Type) NENITA SUAREZ M.D.		23D. ADDRESS CHURCH HOME & HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/14/66		24C. NAME of CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) Balto. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. 12-14-1966		25B. NAME OF REGISTRAR Robert E. Tarkenton, M.D.		25C. FUNERAL DIRECTOR Connelly Sons 300 Magee Ave. Balto. 21 Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06990	
BIRTH NO. 66 06990		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MITZIE BLICKSTEIN		2. DATE AND HOUR OF DEATH 7/9/66 5 10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 15-10			
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 3910 7 MAINE AVENUE	
5. SEX 7	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-29-10	9. AGE (In years last birthday) 55	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LATE ISAAC KOBIN		14. MOTHER'S MAIDEN NAME LIVING MOLLIE POLAKOFF			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. 217-48-6019		17. INFORMANT MR. MEYER BLICKSTEIN, 3910 MAINE AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 416X I CEREBROVASCULAR ACCIDENT		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) EMBOLICATION - ATRIAL FIBRILLATION - RHEUMATIC HEART DISEASE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/8 1966 to 7/9 1966, that (I) (we) last saw the deceased alive on 7/9 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Oscar Fernandini				23B. DATE SIGNED 7/9/66	
23C. PHYSICIAN'S NAME (Type) OSCAR FERNANDINI				23D. ADDRESS LUTHERAN HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/11/66		24C. NAME of CEMETERY or CREMATORY BETH TFILOH CONG.	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN					

THE JOURNAL OF THE
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06991				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06991	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ANNA SCHAEFFER				JULY 8, 1966 7:10 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
90 PALL MALL NURSING HOME				MARYLAND 27-18			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				4911 DENMORE AVENUE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
FEMALE	WHITE	WIDOWED		76			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE			AT HOME		POLAND		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ABRAHAM GELBLUM				CARRIE ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					MR. DE WILKINS, RICHMOND, VIRGINIA 23226 520 WEST VIEW AVENUE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I				Hyper-tensive and arteriosclerosis of Cerebro-vascular disease and coronary insufficiency		years	
ANTECEDENT CAUSES				General Arteriosclerosis		4	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 2-20-66 to 7-8-66, that (I) (we) last saw the deceased alive on 7-8-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Jerome J. Blumberg						7-8-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JEROME J. BLUMBERG				4832 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		7/10/66		MIKRO KODESH BETH ISRAEL		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 11 1966		Robert E. Taylor, M.D.		SOL LEVINSON & BROS. INC.,		6010 REISTERSTOWN	

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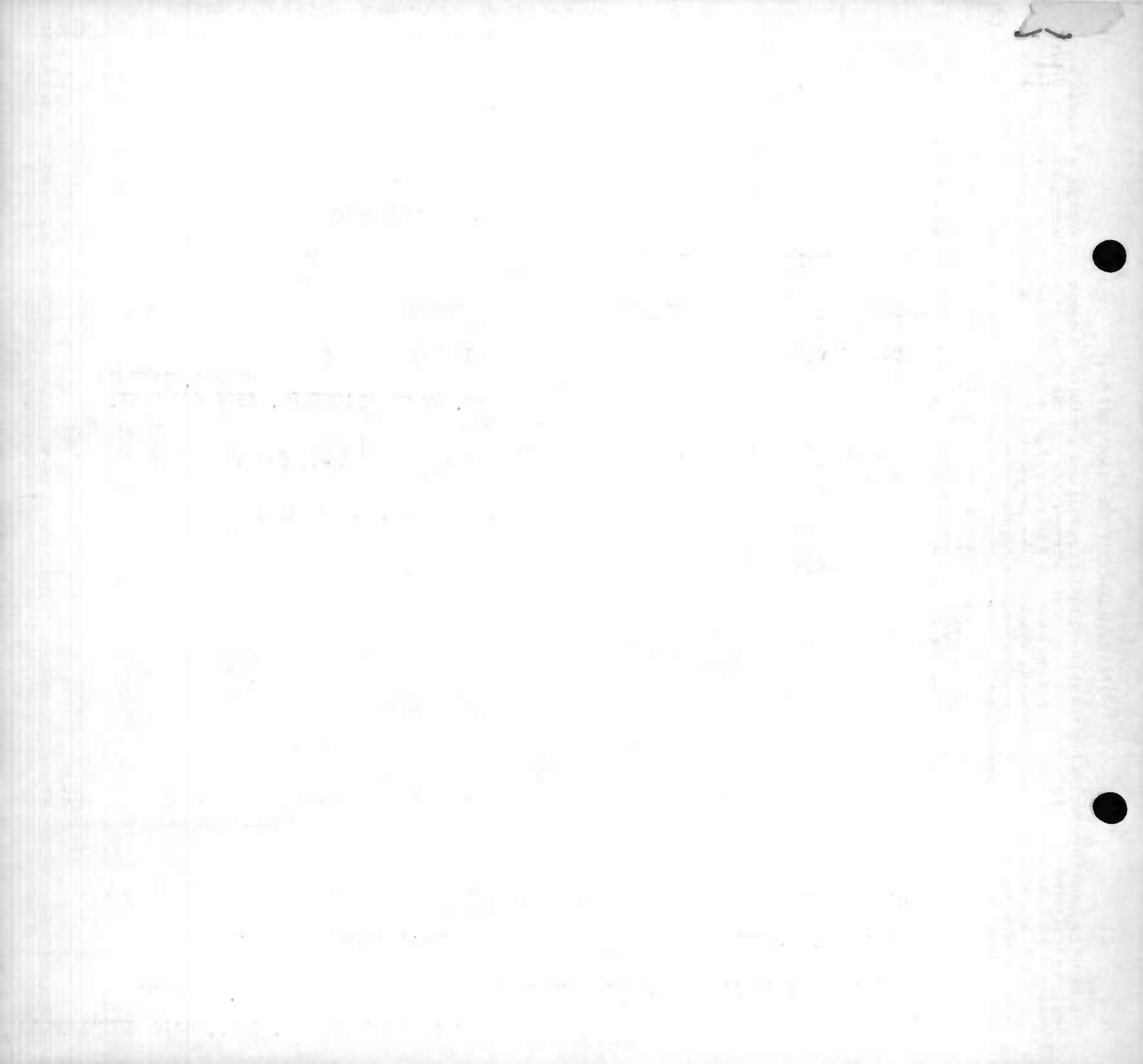
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

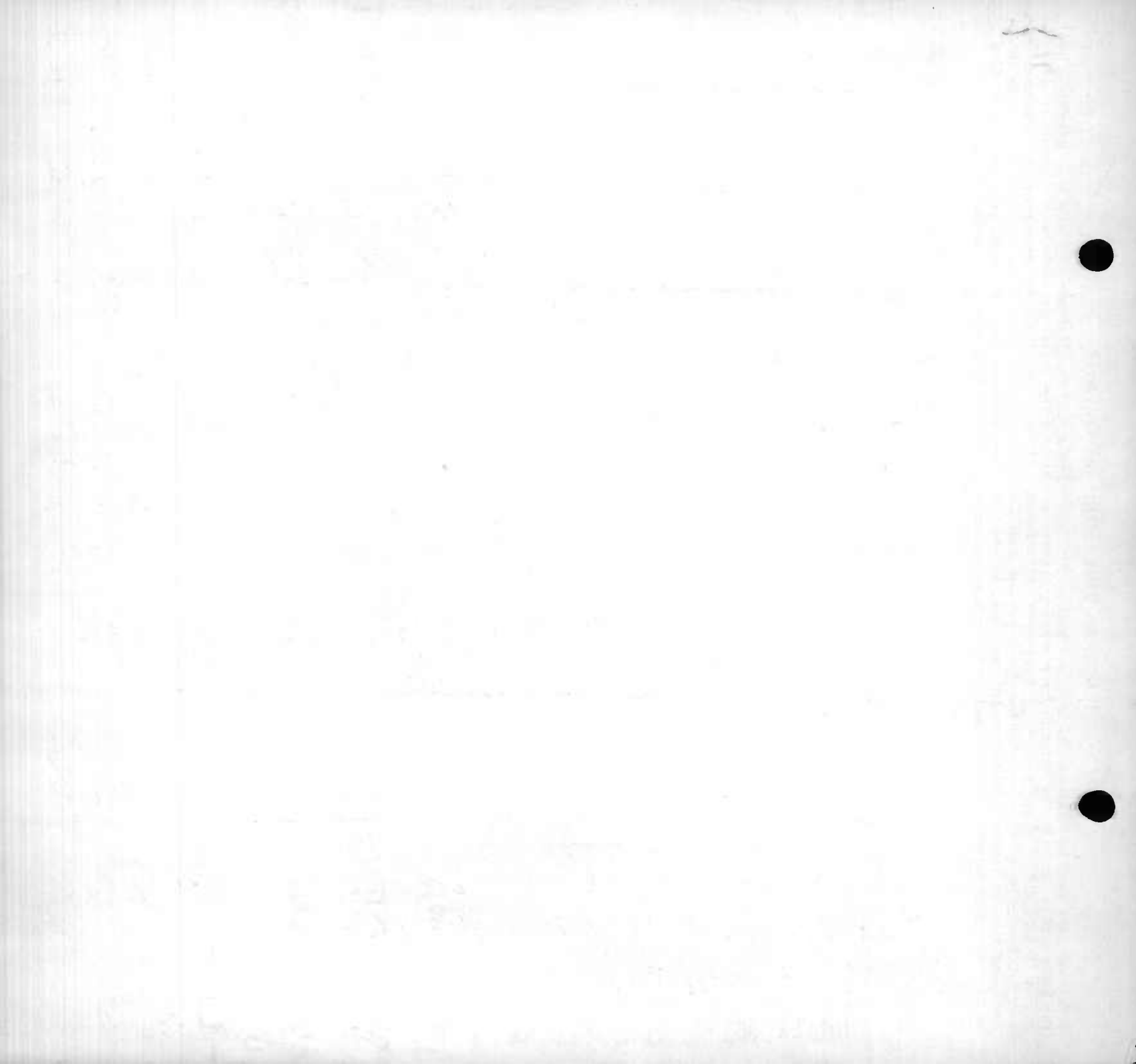
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 06992</u>	
BIRTH NO. <u>66 06992</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>FELDSTEIN, REBECCA</u>		2. DATE AND HOUR OF DEATH <u>7/8/66</u> <u>10 PM</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 SINAI HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-20</u> D. STREET ADDRESS (If rural, give location) <u>6805 WILLIAMSON AVENUE</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH	9. AGE (In years lost birthday) <u>79</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOSHUA SELENKOW</u>		14. MOTHER'S MAIDEN NAME <u>MINDELL ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>VIENNA, VIRGINIA</u> <u>MR. HARRY FELDSTEIN, 8308 COLBY ST.</u>	
18. <u>4/20/1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic CVD</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>7-5</u> 19 <u>66</u> to <u>7-8</u> 19 <u>66</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>7-5</u> 19 <u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley R. Steinbach</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>7-8-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>STANLEY R. STEINBACH</u>		23D. ADDRESS M.D. <u>SINAI HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/10/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>HEBREW YOUNG MEN</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 11 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN</u>			



FUNERAL DIRECTOR: IMPORTANT

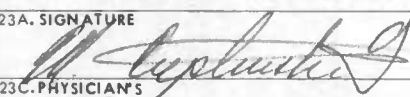
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

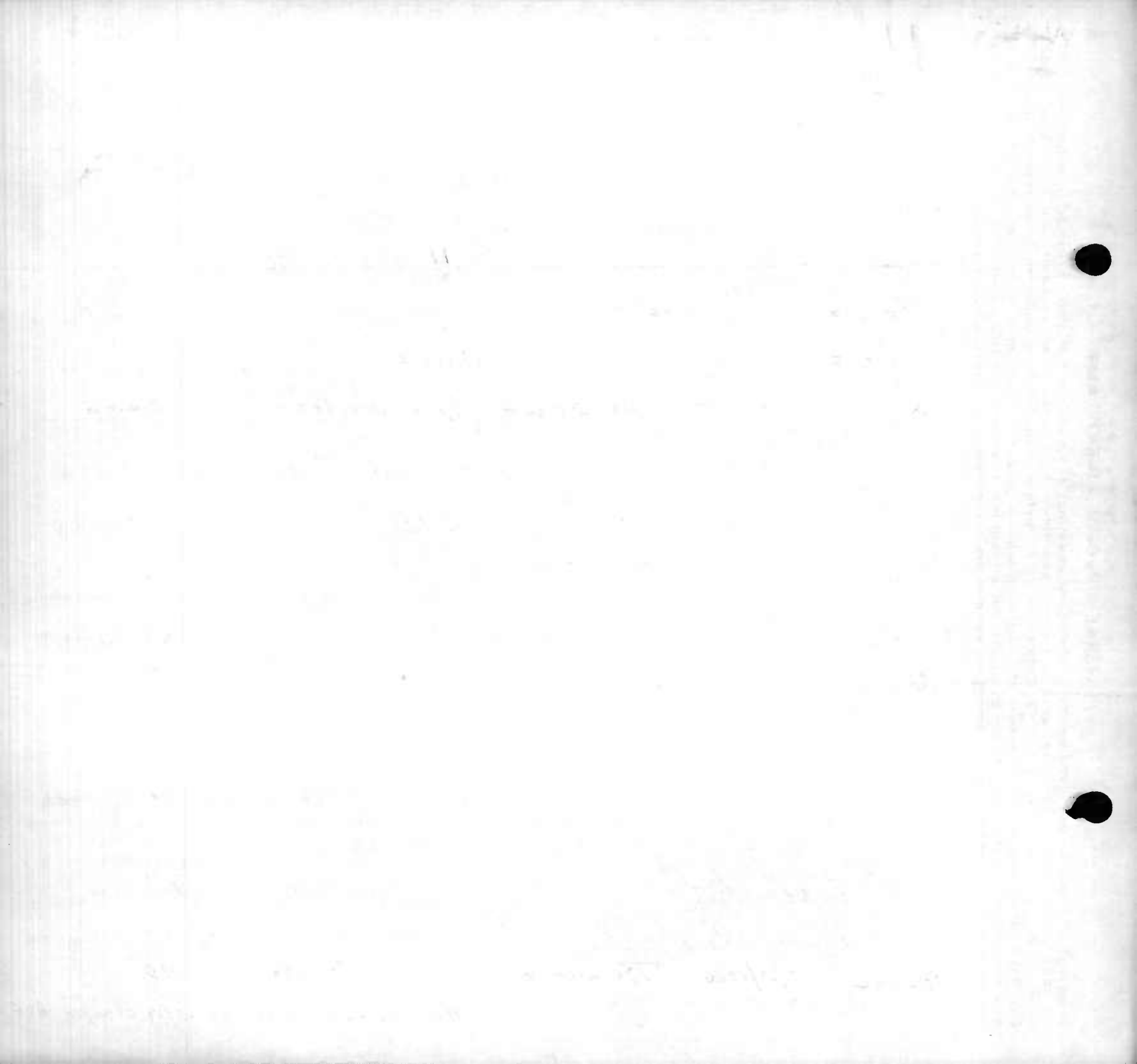
BALTIMORE CITY DEPARTMENT				BIRTH NO. 66 06993		CERTIFICATE OF DEATH		Registered No. 66 06993	
1. NAME OF DECEASED (Type or Print) LULA L. HOFFMAN				2. DATE AND HOUR OF DEATH 7-4-1966 @ 8 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY Hosp.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE M.D. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-36 D. STREET ADDRESS (If rural, give location) 1517 S. CLINTON ST.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-3-1888	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER			10B. KIND OF BUSINESS OR INDUSTRY TAVERN			11. BIRTHPLACE (State or foreign country) M.D.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE YEAGER				14. MOTHER'S MAIDEN NAME ELIZABETH HAAS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-32-2532		17. INFORMANT ADDRESS LULA E. HOFFMAN 1517 S. CLINTON ST.				
18. 260 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Acute Aortic Ulcer DUE TO (B) As. C.V.H.D. DUE TO (C) Chronic Infection			INTERVAL BETWEEN ONSET AND DEATH 5-7 days 5-10 yrs. 15-20 yrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Peripheral vascular insuff. 5 yrs.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Jan 19-1956 to 3 Jan 1966 that (I) (we) last saw the deceased alive on 3 Jan 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE J. B. Bronushas M.D.				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7 Jul 66.			
23C. PHYSICIAN'S NAME (Type) DR. B. BRONUSHAS, M.D.				23D. ADDRESS 30370' Norwell St. Balt 24th					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-7-1966		24C. NAME of CEMETERY or CREMATORY OAKLAWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE M.D.			
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR THELMA A. HOFFMANN		ADDRESS 3218 HUDSON ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

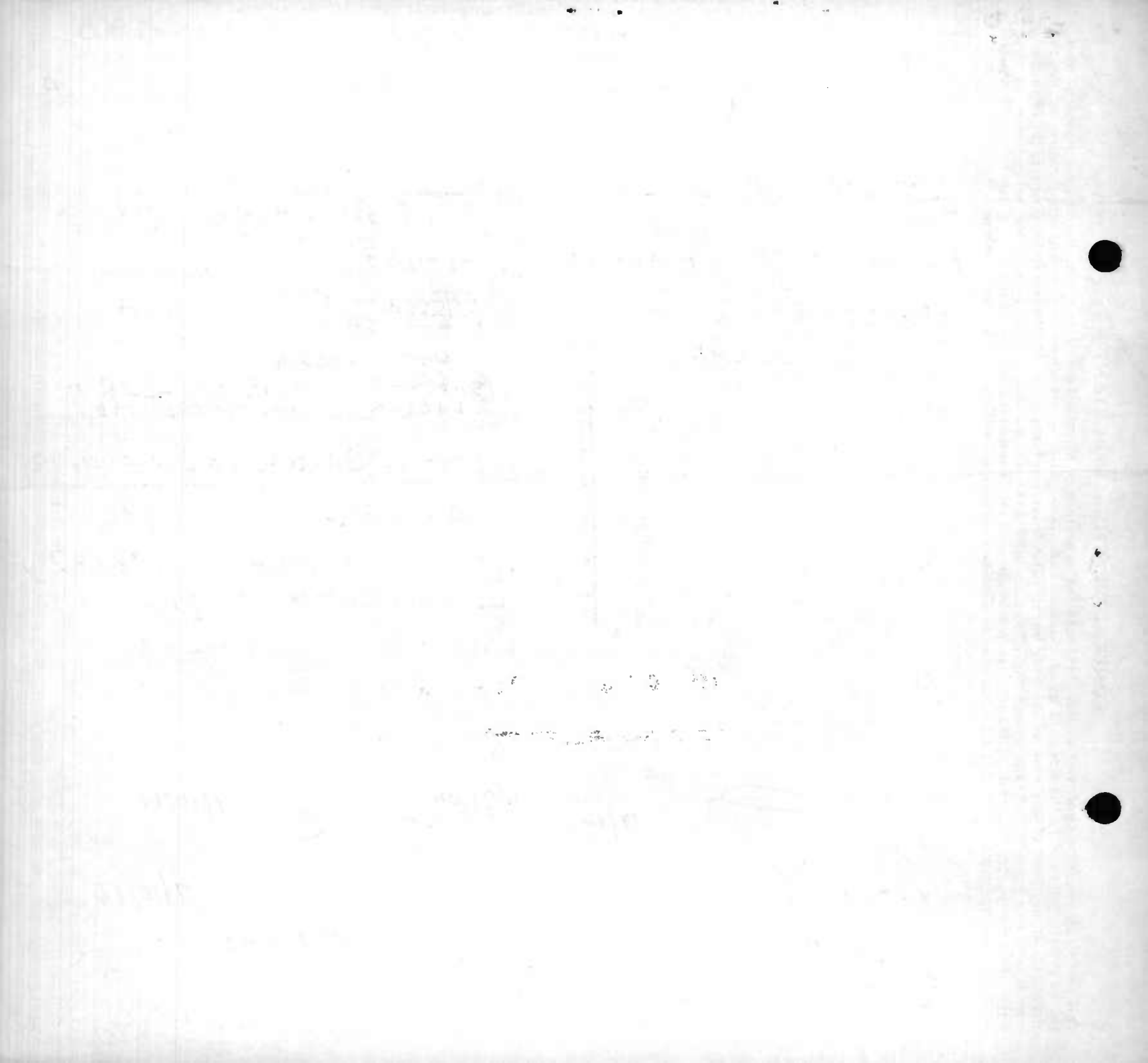
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06994	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 66 06994 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Isadore Walder			2. DATE AND HOUR OF DEATH July 9th 1966 6.50 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Sinai Hospital of Baltimore FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore 5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 6. STREET ADDRESS (If rural, give location) 2608 Oswego Ave		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 18-11-1899	9. AGE (In years last birthday) 76	10. CITIZEN OF WHAT COUNTRY? U.S.A
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY CLERK		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME WOLF			14. MOTHER'S MAIDEN NAME MOLLIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-9785A		17. INFORMANT ROSE WALDER -	
				ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Myocardial Infarction 10 minutes DUE TO (B) ASCVD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Unknown
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute lobar Pneumonia 8 days					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 3rd 1966 to July 9th 1966, that (I) (we) lost saw the deceased alive on July 9th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 9-VII-66	
23C. PHYSICIAN'S NAME (Type) William Cieplinski				23D. ADDRESS Sinai Hospital of Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/14/1966		24C. NAME OF CEMETERY OR CREMATORY ROSEDALE	
24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR SYLVAN J. LEWIS + SON, INC - 3319 OLYMPIA AVE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">66 06995</p> <p style="font-size: 18pt; margin: 0;">BIRTH NO.</p>		<p style="font-size: 24pt; margin: 0;">66 06995</p> <p style="font-size: 18pt; margin: 0;">Registered No.</p>	
<p style="font-size: 24pt; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; margin: 0;">CERTIFICATE OF DEATH</p>			
<p>1. NAME OF DECEASED (Type or Print)</p> <p style="font-size: 24pt; font-weight: bold;">YETTA DUBICK</p>		<p>2. DATE AND HOUR OF DEATH</p> <p style="font-size: 24pt; font-weight: bold;">7/10/66 2:05 A.M.</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p style="font-size: 24pt; font-weight: bold;">SINAI HOSPITAL OF BALTIMORE</p> <p style="font-size: 24pt; font-weight: bold;">42</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MARYLAND</p> <p>B. COUNTY BALTIMORE</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE</p> <p>D. STREET ADDRESS (If rural, give location) 3717 BEEHLER AVE</p>	
<p>5. SEX</p> <p style="font-size: 24pt; font-weight: bold;">FEMALE</p>	<p>6. RACE</p> <p style="font-size: 24pt; font-weight: bold;">WHITE</p>	<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</p> <p style="font-size: 24pt; font-weight: bold;">MARRIED</p>	<p>8. DATE OF BIRTH</p> <p style="font-size: 24pt; font-weight: bold;">10/21/88</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="font-size: 24pt; font-weight: bold;">HOUSEWIFE</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	<p>9. AGE (In years, lost birthday)</p> <p style="font-size: 24pt; font-weight: bold;">77</p>
<p>11. BIRTHPLACE (State or foreign country)</p> <p style="font-size: 24pt; font-weight: bold;">RUSSIA</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="font-size: 24pt; font-weight: bold;">USA</p>	
<p>13. FATHER'S NAME</p> <p style="font-size: 24pt; font-weight: bold;">GELMAN</p>		<p>14. MOTHER'S MAIDEN NAME</p> <p style="font-size: 24pt; font-weight: bold;">NOT KNOWN</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="font-size: 24pt; font-weight: bold;">NO</p>		<p>16. SOCIAL SECURITY NO.</p>	<p>17. INFORMANT</p> <p style="font-size: 24pt; font-weight: bold;">ISADORE DUBICK</p>
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="font-size: 24pt; font-weight: bold;">CONGESTIVE CARDIAC FAILURE 1964 2yr</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p style="font-size: 24pt; font-weight: bold;">1964-2yr</p>	
<p>19. ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="font-size: 24pt; font-weight: bold;">ANEMIA 1964-2yr</p> <p style="font-size: 24pt; font-weight: bold;">APLASTIC ANEMIA 1964-2yr</p> <p style="font-size: 24pt; font-weight: bold;">CHLOROMYCETIN 1964-2yr</p>		<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	
<p>19A. DATE OF OPERATION</p> <p style="font-size: 24pt; font-weight: bold;">0</p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No)</p> <p style="font-size: 24pt; font-weight: bold;">NO</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p><input type="checkbox"/></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p style="font-size: 24pt; font-weight: bold;">00-00</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 6/9/66 19 to 7/10/66 19, that (I) (we) lost saw the deceased alive on 7/10 19 6.6 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p style="font-size: 24pt; font-weight: bold;">David A. Spott</p>		<p>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/></p>	<p>23B. DATE SIGNED</p> <p style="font-size: 24pt; font-weight: bold;">7/10/66</p>
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="font-size: 24pt; font-weight: bold;">Burial</p>		<p>24B. DATE</p> <p style="font-size: 24pt; font-weight: bold;">7/12/66</p>	<p>24C. NAME OF CEMETERY or CREMATORY</p> <p style="font-size: 24pt; font-weight: bold;">B'nai Israel</p>
<p>24D. LOCATION (City, town, or county) (State)</p> <p style="font-size: 24pt; font-weight: bold;">Balto Md</p>		<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p style="font-size: 24pt; font-weight: bold;">JUL 11 1966</p>	
<p>25B. NAME OF REGISTRAR</p> <p style="font-size: 24pt; font-weight: bold;">Robert E. Fairley</p>		<p>25C. FUNERAL DIRECTOR</p> <p style="font-size: 24pt; font-weight: bold;">Sylvan S. Lewis</p>	
<p>25D. ADDRESS</p> <p style="font-size: 24pt; font-weight: bold;">3319 Olympian</p>		<p>25E. ADDRESS</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 06996		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 06996	
M.E. CASE NO. ARAUJO		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 4:55 8 July 66 4:55 P.M.	
1. NAME OF DECEASED (Type or Print) Araujo, Oswaldo		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION 38 Univ. of Md. Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE DC B. COUNTY V-48		C. CITY OR TOWN (If outside city limits, write RURAL and give township) WASHINGTON, DC	
D. STREET ADDRESS (If rural, give location) 3526 Yuma St. N.W.		5. SEX M 6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	
8. DATE OF BIRTH 4/29/39		9. AGE (In years lost birthday) 27		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	
11. BIRTHPLACE (State or foreign country) Venezuela		12. CITIZEN OF WHAT COUNTRY? Venezuela		13. FATHER'S NAME Araujo	
14. MOTHER'S MAIDEN NAME Mercedes Araujo		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hosp. Records		ADDRESS		18. 331 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)	
INTERVAL BETWEEN ONSET AND DEATH 5 min		CAUSE OF DEATH (A) Respiratory paralysis DUE TO (B) Brain damage DUE TO (C) Acute intracranial hemorrhage		27 hrs 27 hrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7 July 1966 to 8 July 1966, that (I) (we) lost saw the deceased alive on 8 July 66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Roberto A. Negrón		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8 July 66	
23C. PHYSICIAN'S NAME (Type) Roberto A. Negrón		23D. ADDRESS Univ. Hosp. Bldg. Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Removal	
24B. DATE 7/11/66		24C. NAME OF CEMETERY or CREMATORY Coracas General Cemetery		24D. LOCATION (City, town, or county) (State) Caracos, Venezuela	
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., Balto., Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 06997	
BIRTH NO. 66 06997		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Daisy Schabdach.		2. DATE AND HOUR OF DEATH 7/10/66 12 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital 44		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 9-01 D. STREET ADDRESS (If rural, give location) 3915 Kimball Rd. Kimble			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 11/4/93	9. AGE (In years lost birthday) 72	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Retired for 6 yrs.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Leonard Schabdach		14. MOTHER'S MAIDEN NAME Helene Schwabe	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-10-3374		17. INFORMANT Mrs Paul Horn - Sister	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 90 min			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 10 12:45AM 66 to June 10 2AM 66 , that (I) was lost saw the deceased alive on June 10 19 66 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.					
23A. SIGNATURE Alan B. Cohen M.D., Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED June 10, 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. 3501 ST Paul Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-13-66		24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK	
24D. LOCATION (City, town, or county) (State) BALTO Md					
25A. DATE REC'D BY HEALTH DEPT JUL 11 1966		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Leonard J. Puck Inc	
				ADDRESS 5305 Hayford	

May 1900

Union Memorial

May 1900

May 1900

May 1900

May 1900

May 1900

May 1900

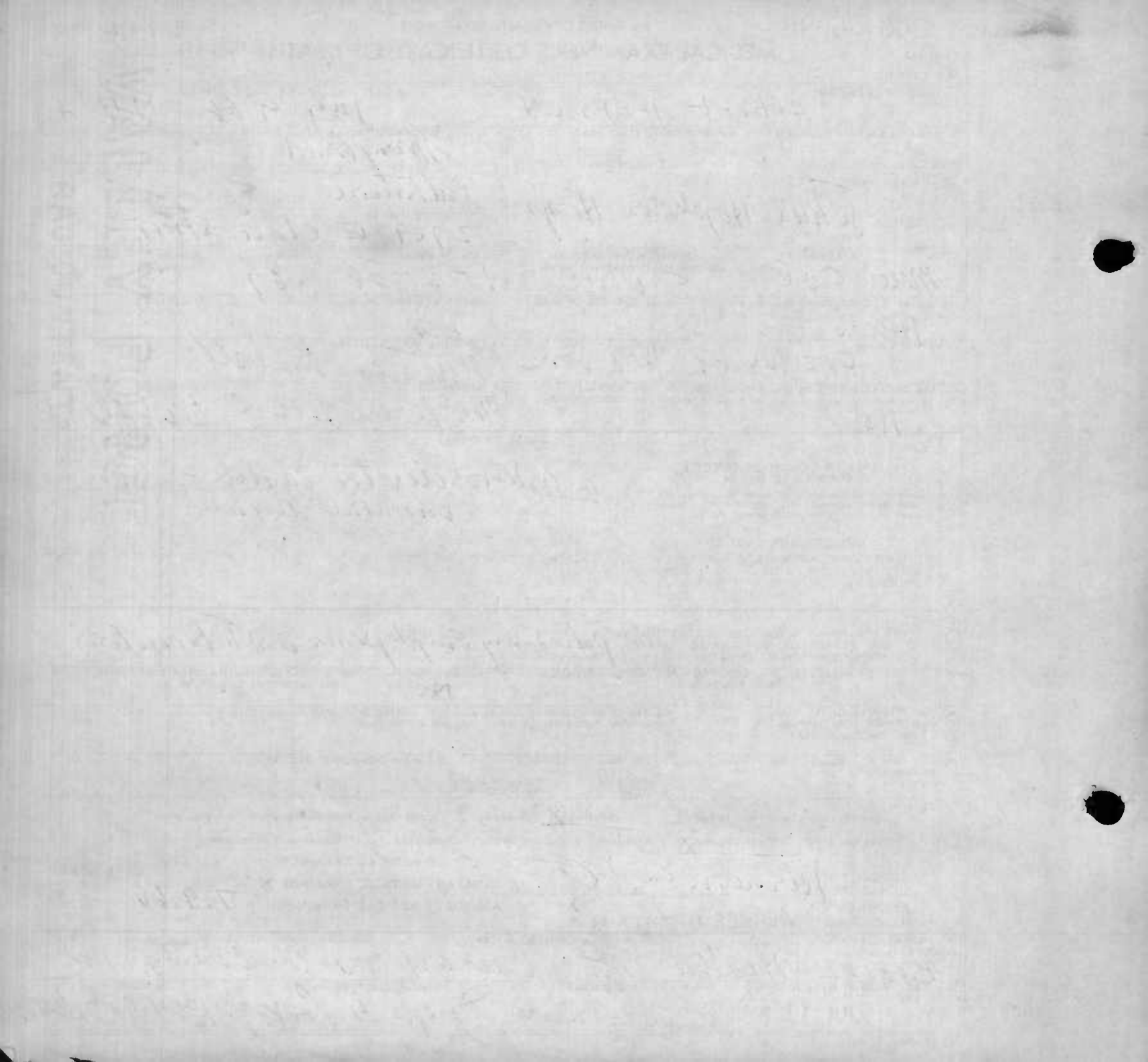
May 1900

May 1900

May 1900

May 1900

66 06998		BALTIMORE CITY HEALTH DEPARTMENT		66 06998	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Albert HEBRON		2. DATE AND HOUR PRONOUNCED DEAD July 9 66 1 12 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hosp		A. STATE Maryland B. COUNTY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore S-03			
		D. STREET ADDRESS (If rural, give location) 2709 E. Chase Street			
5. SEX Male	6. RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 1-2-99	9. AGE (In years last birthday) 67	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
13. FATHER'S NAME Frederick Hebron		14. MOTHER'S MAIDEN NAME Matilda Kimball			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Ethel Brown 2616 E. Biddle St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 + 1002.1		CAUSE OF DEATH (A) <u>arteriosclerotic cardio-vascular disease</u> (B) <u>DUE TO</u> (C) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. pulmonary Emphysema and Tuberculosis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		7.9.66	
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 7/12/66		23C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
23D. LOCATION (City, town, or county) (State) D.A. County, Md.		24A. DATE REC'D BY HEALTH DEPT. JUL 11 1966			
24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR Joseph B. Locks		24D. ADDRESS 1304 N. Central	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 06999		CERTIFICATE OF DEATH		Registered No. 66 06999		
1. NAME OF DECEASED (Type or Print) CAMPBOR, Walter				2. DATE AND HOUR OF DEATH 7 July 1966 2:35 p. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 92 Maryland Penitentiary Hospital 954 Forrest Street, Baltimore, Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1103 Vine Street, Baltimore, Maryland						
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 2 April 1932	9. AGE (In years last birthday) 34	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Camphor				14. MOTHER'S MAIDEN NAME Ida Woodridge						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 1-1-1-1-1-1-1-1-1-1		17. INFORMANT Ida Camphor 1103 Vine St.				ADDRESS	
18. 2041 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) myeloid Leukemia DUE TO				INTERVAL BETWEEN ONSET AND DEATH 9 mos.		
				(B) DUE TO						
				(C) DUE TO						
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				19A. DATE OF OPERATION 11-17-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Spleen		20A. AUTOPSY? (Yes or No)		
								20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1 December 19 65 to 7 July 19 66 , that (I) (we) last saw the deceased alive on 7 July 66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE Henry W.D. Holljes				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 7 July 1966		
23C. PHYSICIAN'S NAME (Type) Henry W.D. Holljes				23D. ADDRESS 954 Forrest Street, Baltimore, Maryland						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 11/66		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.			24D. LOCATION (City, town, or county) (State) Ceder Hill Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 11 1966		25B. NAME OF REGISTRAR R. E. Fisher, M.D.			25C. FUNERAL DIRECTOR Williams Funeral Home			ADDRESS 319 N. Schroeder St.		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 07000</u>	
BIRTH NO. <u>66 07000</u>		M.E. CASE NO. <u>66 07000</u>		1. NAME OF DECEASED (Type or Print) <u>SCARBOROUGH, MILDRED TWINING</u>		2. DATE AND HOUR OF DEATH <u>July 7, 1966 303 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>527 St. Francis Rd</u>			
5. SEX <u>f</u>	6. RACE <u>wh.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>m.</u>	8. DATE OF BIRTH <u>09-13-07</u>	9. AGE (In years last birthday) <u>58</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC TWINING</u>				14. MOTHER'S MAIDEN NAME <u>SARAH BURTON</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. LAWRENCE C. SCARBOROUGH</u>		ADDRESS <u>527 St. Francis Rd. 21204</u>	
18. <u>332 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Subarachnoid Hemorrhage</u> DUE TO <u>ARTERY ②</u> (B) <u>OCCLUSION OF INT. CAROTID</u> DUE TO (C) <u>HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>undetermined</u> <u>14 days</u> <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 24</u> 19 <u>66</u> to <u>July 7</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 7</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Zoltan Zarday</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>July 7 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>ZOLTAN ZARDAY</u>				23D. ADDRESS M.D. <u>THE UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-11-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>PARKVILLE BALTO. COUNTY</u> <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 11 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>WM. COOK-BROOKS TOWSON INC.</u>		ADDRESS <u>1050 York Rd</u>	

